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| COORDINATED SERVICE AND SUPPORT PLAN (CSSP) ADDENDUM |
| Name of person served: Jonathan Green    Date of development: 10/28/2015  For the annual period from: 10/28/2015 to 10/27/2016  Name and title of person completing the *CSSP Addendum*: Dhimbil Ali, Program Manager  Legal representative: Angelique Harkness (mother) is guardian.  Case manager: Dasie Richmond  Other support team members:  Current meeting: Intake 45-day  Annual  Semi-annual  Quarterly  Request to meet:  Annually  Semi-annually  Quarterly |
| Dates of development:   * Within 15 days of service initiation, the license holder must complete the preliminary *Coordinated Service and Support Plan Addendum* based upon the *Coordinated Service and Support Plan.* * Within 45 calendar days of service initiation, the license holder must meet with the support team and make determination regarding areas listed in this addendum. * Annually, the support team reviews the *Coordinated Services and Support Plan Addendum.* |

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| **CLIENT IDENTIFYING INFORMATION** |
| |  |  | | --- | --- | | Consumer Name: Jonathan Green  DOB: 9/15/1996  Sex: Male  Weight: 175lbs  Eye Color: Hazel/Blue  Race: White  Height: 5’ 10”  Hair Color: Sandy Blonde | Address: 2923 Knox Ave. Minneapolis, MN  Phone: 763-203-2471  Religious Preference: Wiccan | |

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| **SERVICE DATA** |
| Intake Date: September 21, 2009  Legal Status: Angelique Harkness (mother) is guardian.  Service Initiation Date: October 1, 2009  County of Financial Responsibility: Hennepin  County of Service Responsibility: Hennepin |

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| **FINANCIAL RESOURCES** |
| Social Security Number: 476-31-5384  Medical Assistance Number: 01267560  Medicare Number:  Type: (MSA, RSDI, SSI, wages)  Amount/Month:  Savings Account Balance: Financial Institution:  Checking Account Balance: Financial Institution:  Burial Account Balance: Financial Institution: |

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| **CLIENT SPECIFIC INFORMATION** |
| Mobility: Ambulatory  Use of Public Transportation: Jonathan utilizes the school bus and the city bus.  Self-Cares: Semi-Independent, requires verbal prompts.  Domestic: Semi-Independent, requires verbal prompts.  Eating: Jonathan may require assistance cutting up food.  Primary Mode of Communication: Verbal  Adaptive Equipment or Appliances: Jonathan utilizes corrective lenses.  Is able to drink alcohol? No  Identify form of Personal Identification (card, bracelet, necklace...)? State ID |

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| **DESCRIBE CONSUMER INTERESTS** |
| Jonathan enjoys playing video games, playing on the computer, watching T.V., building things and playing soccer. |

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| **HEALTH INFORMATION** |
| **Diagnosis**: ADHD and Autism  **Seizures**: No  **Protocol on file**: NA |
| Current Prescription Medications:   |  |  |  |  | | --- | --- | --- | --- | | **Medication:** | **Dosage:** | **Time:** | **Reason:** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |
| **Allergies:** Augmentin  **Special Diet:** Jonathan cannot have 100% grape juice or imitation crab meat. |

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| **CONSUMER CONTACTS / LICENSE HOLDERS** |
| |  |  | | --- | --- | | **Emergency Contact Person(s): Brian Harkness**  Address: 2923 Knox Ave North Minneapolis, MN  Phone Number**:** 763-203-2471  Cell:  Fax:  E-Mail: | **Family Choice of Alternate Emergency Contact:** **Lynette Sanders**  Address:  Phone Number: 763-203-2473  Cell:  Fax:  E-Mail: | | **Legal Representative: Angelique (Angel) Harkness** Address: 2923 Knox Ave. Minneapolis, MN  Phone: 763-203-2475  Cell: 763-203-2471  Fax:  E-Mail: [Akharkness@yahoo.com](mailto:Akharkness@yahoo.com) | **Respite Provider: MSSA (Metro Social Services)**  Address:  Phone Number:  Cell: 651-353-1453  Fax:  E-Mail:  Contact Person: Ricky Larson | | **Residential Provider: NA**  Address:  Phone Number:  Cell:  Fax:  E-Mail:  Contact Person: | **County Case Manager: Dasie Richmond**  Address:  Phone Number: 612-543-0510  Cell:  Fax:  E-Mail: [Dasie.Richmond@hennepin.us](mailto:Dasie.Richmond@hennepin.us) | | **County Financial Worker: Team 460**  Address: Hennepin County  Phone Number: 612-596-1300  Cell:  Fax:  E-Mail: | **Behavioral Analyst: NA**  Address:  Phone Number:  Cell:  Fax:  E-Mail: | | **Current School/Day Program/Work: Transition Plus High School**  Address: 3320 Elliot Ave S, Minneapolis, MN 55407  Phone Number: (612) 668-4100  Cell:  Fax:  E-mail: | **Physician: Dr. Mayrand, Aspen Maplewood Clinic**  Address: 1850 Beam Ave Maplewood, MN  Phone Number: 779-2500  Cell:  Fax:  E-Mail: | | **Hospital of Preference: Children’s Hospitals**  Address: 2525 Chicago Ave. Minneapolis, MN  Phone Number: 612-813-6000  Cell:  Fax:  E-Mail: | **Dentist:**  Address:  Phone Number:  Cell:  Fax:  E-Mail | | **Psychologist: Dr. Navid Aliaghai, Aspen Bandana Clinic**  Address: 280 Smith Ave N. Suite 450 St. Paul, MN 55102  Phone: 651-241-5959 |  | |

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| **HIGH QUALITY SERVICES CONTACTS** |
| **Program Manager: Dhimbil Ali**  Phone: 612-730-2130  Email: [Dhimbil.Ali@High QualityServices.org](mailto:Dhimbil.Ali@PinnacleServices.org)  **Program Director: Jessica Reno**  Phone: 612-977-3105  E-mail: [Jessica.Reno@High Qualityservices.org](mailto:Jessica.Reno@pinnacleservices.org)  **Program Administrator: Jamie Fann**  Phone 612-977-3115  E-mail: [Jamie.Fann@High QualityServices.org](mailto:Jamie.Fann@PinnacleServices.org)  **Chief Executive Officer: Jill Cihlar**  Phone: 612-977-3111  E-mail: Jill.Cihlar@High QualityServices.org  **Chairman: Nic Thomley**  Phone: 612-977-3110  E-mail: [Nic.Thomley@High QualityServices.org](mailto:Nic.Thomley@PinnacleServices.org) |

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| **REVIEW INCIDENT LOG & CORRECTION PLAN** |
| **NA** |

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| **SUMMARY OF RELEVANT EVENTS FOR CONSUMER** |
| **NA** |

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| **REVIEW OF ASSESSMENTS/EVALUATIONS** |
| |  |  | | --- | --- | | Annual Physical: | Recall Date: | | Dental Exam: | Recall Date: | | Vision Exam: | Recall Date: | | Hearing Eval: | Recall Date: | | Psychological Eval: | Recall Date: | | Neurological Eval: | Recall Date: | | Psychiatric Eval: | Recall Date: | | Speech Assessment: | Recall Date: | | OT Assessment: | Recall Date: | | PT Assessment: | Recall Date: | | Tetanus Vaccination: | Recall Date: | | Depo-Provera Shot: | Recall Date: | | Individual Service Plan: | Recall Date: | | Flu Shot: | Recall Date: | | Other: | Recall Date: | |

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| HEALTH NEEDS |
| Indicate what health service responsibilities are assigned to this license holder and which are consistent with the person’s health needs. If health service responsibilities are not assigned to this license holder, please state “NA”: NA If health service responsibilities are assigned to this license holder, you will be promptly notified of any changes in the person’s physical and mental health needs affecting the health service needs. |
| If the license holder is assigned responsibility for medication assistance or medication administration, the license holder will provide medication administration or assistance (including set up) according to the level indicated here:  Medication set up  Medication assistance  Medication administration  NA |
| The following information will be reported to the legal representative and case manager as they occur, unless otherwise indicated here:  * Any report made according to 245D.05, subdivision 2, paragraph (c), clause (4) * The person’s refusal or failure to take or receive medication or treatment as prescribed. * Concerns about the person’s self-administration of medication or treatments. |
| PSYCHOTROPIC MEDICATION MONITORING AND USE |
| If this person is prescribed psychotropic medication and this license holder has been assigned responsibility for medication administration, the following information will be maintained by the license holder. Please refer to the Behavior Outcome and Psychotropic Medication Monitoring Data Report for more information. Is this person prescribed psychotropic medication?  Yes  No Describe the target symptoms the psychotropic medication is to alleviate: NA Indicate what documentation method(s) will be used to monitor and measure changes in the target symptoms:  High Quality is not contracted to monitor or measure target symptoms of psychotropic medications. |

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| **SERVICES AND SUPPORTS** |
| Can this person use **dangerous items or equipment**?  Yes  No  If yes, address any concerns or limitations: |
| Has it been determined by the person’s physician or mental health provider to **be medically or psychologically contraindicated to use an emergency use of manual restraint** when a person’s conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety?  Yes  No  If yes, the company will not allow the use of the behavioral intervention/manual restraint to be used for the person. |
| The person’s **preferences for how services and supports are provided**: **None** |
| Is the current service setting the **most integrated setting available and appropriate** for the person?  Yes  No If no, please describe what will be done to address this: |
| How will services be **coordinated across other 245D licensed providers** **and members of the support team or expanded support team** serving this person to ensure continuity of care and coordination of services?    The team will meet semi-annually, as well as communicate any changes in Jonathan’s behavior and incident or vulnerable adult reports involving Jonathan.  If there is a **need for service coordination** between providers, include the name of service provider, contact person and telephone numbers, services being provided, and the names of staff responsible for coordination:    **Legal Representative: Angelique (Angel) Harkness**  Address: 2923 Knox Ave. Minneapolis, MN  Phone: 763-203-2475  Cell: 763-203-2471  **County Case Manager: Dasie Richmond**  Phone Number: 612-543-0510  E-Mail: [Dasie.Richmond@hennepin.us](mailto:Dasie.Richmond@hennepin.us)  **Psychologist: Dr. Navid Aliaghai, Aspen Bandana Clinic**  Address 1021 Energy Park Dr. St. Paul, MN  Phone: 651-241-9700  **Current School/Day Program/Work: Edison High School**  Address: 700 22nd Ave. NE Minneapolis, MN 55418  Phone Number: 612-668-1300  Fax: 612-668-1320 |
| Does the person require the **presence of staff** at the service site while services are being provided?  Yes  No  If no, please provide information on when staff do not need to be present with this person (include community, home, or work) and for the length of time. If additional information regarding safety plan is needed, also provide: |
| Does the person require a **restriction of their rights** as determined necessary to ensure the health, safety, and well-being of the person?  Yes  No  If yes, indicate what right(s) are restricted:  Refer to the attached *Rights Restrictions* form for all additional requirements and documentation. |

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| PERMITTED ACTIONS AND PROCEDURES |
| Has it been determined by the person’s physician or mental health provider to **be medically or psychologically contraindicated to use an emergency use of manual restraint** when a person’s conduct poses an imminent risk of physical harm to self or others and less restrictive strategies would not achieve safety?  Yes  No  If yes, the company will not allow the use of the behavioral intervention/manual restraint to be used for the person. |
| Is a restraint needed as an **intervention procedure to position this person** due to physical disabilities?  Yes  No  If yes, please specify the manner in which the restraint is/will be used: |
| What **positive support strategies** may be attempted as a means to de-escalate the person’s behavior before it poses an imminent risk of physical harm to self or others?  NA – this person does not have behaviors that would pose an imminent risk of physical harm to others.  **Positive support strategies** include: |
| Does the person require the **use of permitted actions and procedures or instructional techniques and intervention procedures on a continuous basis** as identified in 245D.06, subdivision 7, paragraphs (b) and (c)?  Yes  No  If yes, please address how these are used as part of service provision according to 245D.07 and 245D.071, *Service Planning and Delivery*: |

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| **STAFF INFORMATION** |
| Are any **additional requirements** requested for staff to have or obtain in order to meet the needs of the person?  Yes  No  If yes, please specify what these requirements are: |
| Does a staff person who is **trained in cardiopulmonary resuscitation (CPR)** need to be available when this person is present and staff are required to be at the site to provide direct service?  Yes  No |

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| **FREQUENCY OF REPORTS AND NOTIFICATIONS** |
| \*Information received regarding the frequency of reports and notifications is completed with the person served and/or legal representative and case manager.   1. Frequency of *Progress Reports and Recommendations*, at a minimum of annually:   Quarterly  Semi-annually  Annually   1. Frequency of progress review meetings, at a minimum of annually:   Quarterly  Semi-annually  Annually   1. Frequency of receipt of *Psychotropic Medication Monitoring Data Reports*, this will be done quarterly unless otherwise requested or specified by prescriber:   Quarterly  Other (specify): **NA**   1. Frequency of medication administration record reviews, this will be done quarterly or more frequently as directed (for licensed holders when assigned responsibility for medication administration):   Quarterly  Other (specify): **NA**   1. The legal representative and case manager will receive notification within 24 hours of an incident or emergency occurring while services are being provided or within 24 hours of discovery or receipt of information that an incident occurred, or as otherwise directed. Please indicate any changes regarding this notification: 2. Request to receive the *Progress Report and Recommendation*:   At the support team meeting; or  At least five working days in advance of the support team meeting.   1. Frequency of receiving a financial statement that itemizes receipt and disbursements of funds.   Quarterly  Semi-annually  Annually  Other (specify):  NA |

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| **CONFERENCE MINUTES (Summary of team discussion/determinations)** |
| Meeting Date: 10/30/2015  Meeting Attendance: Brian & Angelique (Angel) Harkness, Dhimbil Ali, Dasie Richmond, and Jonathan Green  Description of Consumer’s participation in conference process: Jonathan answered questioned to the best of his abilities.  Review of Guardianship or Conservatorship Status:  Review of Placement and Appropriateness:  Description of Relevant Health Issues: There are no new health issues. |
| Description of Relevant Behavioral Issues: |
| Other discussion: None |

**SIGNATURE PAGE**

**By signing below, I am indicating the completion and approval of *Coordinated Service and Support Plan Addendum*.**

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| Person served: | Date: |
| Legal representative: | Date: |
| Case manager: | Date: |
| Licensed provider contact: | Date: |
| Other support team member (name and title): | Date: |
| Other support team member (name and title): | Date: |