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**Individual Abuse Prevention Plan (IAPP)**

**Person’s Name: Meeting date:**

**Instructions**: For each area, assess whether the person is susceptible to abuse by others and the person’s risk of abusing others. If susceptible, indicate why by checking/adding the appropriate reason. Identify specific measures to be taken to minimize risk within the scope of licensed services and identify referrals needed when the person is susceptible outside the scope/control of the licensed services. If the person does not need specific risk reduction measures in addition to those identified in the program abuse prevention plan, document this determination and identify the area of the program prevention plan that addresses the area of susceptibility.

1. **Sexual abuse**

Is the person susceptible to abuse in this area?  Yes (if any area below is checked)  No

Lack of understanding of sexuality

Likely to seek or cooperate in an abusive situation

Inability to be assertive

Other:

Specific measures to minimize risk of abuse for each area checked:

Referrals made when the person is susceptible to abuse outside the scope or control of this program (Identify the referral and the date it occurred).

1. **Physical Abuse**

Is the person susceptible to abuse in this area?  Yes (if any area below is checked)  No

Inability to identify potentially dangerous situations

Lack of community orientation skills

Inappropriate interactions with others

Inability to deal with verbally/physically aggressive persons

Verbally/physically abusive to others

“Victim” history exists

Other:

Specific measures to minimize risk of abuse for each area checked:

Referrals made when the person is susceptible to abuse outside the scope or control of this program (Identify the referral and the date it occurred).

1. **Self Abuse**

Is the person susceptible to abuse in this area?  Yes (if any area below is checked)  No

Dresses inappropriately

Refuses to eat

Inability to care for self-help needs

Lack of self-preservation skills (ignores personal safety)

Engages in self-injurious behaviors

Neglects or refuses to take medications

Other:

Specific measures to minimize risk of abuse for each area checked:

Referrals made when the person is susceptible to abuse outside the scope or control of this program (Identify the referral and the date it occurred).

1. **Financial Exploitation**

Is the person susceptible in this area?  Yes (if any area below is checked)  No

Inability to handle financial matters

Other:

Specific measures to minimize risk of abuse for each area checked:

Referrals made when the person is susceptible to abuse outside the scope or control of this program (Identify the referral and the date it occurred).

1. **Is the program aware of this person committing a violent crime or act of physical aggression toward others?**  Yes  No

Specific measures to be taken to minimize the risk this person might reasonably be expected to pose to visitors to the program and persons outside the program, if unsupervised:

Referrals made when the person is susceptible to abuse outside the scope or control of this program (Identify the referral and the date it occurred).

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**Individual Abuse Prevention Plan (IAPP)**

Signature Page

An individual abuse prevention plan is developed for each new person as part of the initial service plan. The person will participate in the development of the plan to the full extent of their ability. When applicable, the person’s legal representative will be given the opportunity to participate with or for the person in the development of the plan. The interdisciplinary team will document the review of the plan at least annually, using an individual assessment, as required in MN Statutes, section 245D.071, subd. 3, and any reports of abuse relating to the person. The plan shall be revised to reflect the results of this review.

Signatures of those reviewing and/or participating in the development of this plan:

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