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| COORDINATED SERVICE AND SUPPORT PLAN (CSSP) ADDENDUM |
| Name of person served: Derrick Mallory    Date of development: 10/16/2015  For the annual period from: 10/23/2015 to 10/22/2016  Name and title of person completing the *CSSP Addendum*: Jill Manthei, Program Coordinator  Legal representative: Lealer Mallory  Case manager: Emilie Fisch  Other support team members: Deborah Holl  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.* |
| **CLIENT IDENTIFYING INFORMATION** |
| |  |  | | --- | --- | | Consumer Name: Derrick Mallory  DOB: 12/20/1985  Sex: Male  Weight: 159lbs  Eye Color: Brown  Race: African American  Height: 5’9”  Hair Color: Black | Address: 1206 2nd Street NE #204  Minneapolis, MN  Phone: 612-990-6615  Religious Preference: None | |
| **SERVICE DATA** |
| Intake Date: August 6th 2012  Legal Status: Private, Lealer Mallory is guardian.  Service Initiation Date: August 31st 2012  County of Financial Responsibility: Hennepin (DD waiver)  County of Service Responsibility: Hennepin |
| **FINANCIAL RESOURCES** |
| Social Security Number: 382-96-0840  Medical Assistance Number: 00065514  Medicare Number: N/A  Type: (MSA, RSDI, SSI, wages)  Amount/Month:  Savings Account Balance: Financial Institution:  Checking Account Balance: Financial Institution:  Burial Account Balance: Financial Institution: |
| **CLIENT SPECIFIC INFORMATION** |
| Mobility: Ambulatory  Use of Public Transportation: Independent  Self-Cares: Semi-Independent, Derrick will utilize staff prompts.  Domestic: Semi-Independent, Derrick will utilize staff prompts.  Eating: Independent  Primary Mode of Communication: Verbal  Adaptive Equipment or Appliances: None  Is able to drink alcohol? No  Identify form of Personal Identification (card, bracelet, necklace...) Minnesota Identification Card |
| **DESCRIBE CONSUMER INTERESTS** |
| Derrick is interested in computers and the internet. Derrick enjoys Facebook and going to the library to use the computers. Derrick enjoys seeing movies, going out to eat pizza, sports, watching TV, listening to music, texting and going to barber school. |
| **HEALTH INFORMATION** |
| **Diagnosis**: Autism Spectrum Disorder, Pulmonary Stenosis of the heart  **Seizures**: None  **Protocol on file**: N/A |
| Current Prescription Medications:   |  |  |  |  | | --- | --- | --- | --- | | **Medication:** | **Dosage:** | **Time:** | **Reason:** | | Aspirin | 325mg | Morning | Valve replacement-to prevent blood clots. | |  |  |  |  | |  |  |  |  | |  |  |  |  | |
| **Allergies:** N/A  **Special Diet:** N/A |
| **CONSUMER CONTACTS / LICENSE HOLDERS** |
| |  |  | | --- | --- | | **Emergency Contact Person(s): Lealer Mallory-Wiggins**  Address: 2766 McNair Drive  Robbinsdale, MN 55422  Phone Number: 763-529-4243  Cell:  Fax:  E-Mail: raiscinkids@q.com | **Family Choice of Alternate Emergency Contact: Cleatus Mallory**  Address:  Phone Number: 612-817-2794  Cell:  Fax:  E-Mail: | | **Legal Representative: Lealer Mallory-Wiggins**  Address: 2766 McNair Drive  Robbinsdale, MN 55422  Phone Number: 763-529-4243  Cell:  Fax:  E-Mail: raiscinkids@q.com | **Parents: Lealer Mallory-Wiggins**  Address: 2766 McNair Drive  Robbinsdale, MN 55422  Phone Number: 763-529-4243  Cell:  Fax:  E-Mail: raiscinkids@q.com: | | **Residential Provider: Lifeworks Personal Support**  Address: 2965 Lone Oak Drive, Suite 160  Eagan, MN 55121  Phone Number: 651-454-2732  Cell:  Fax: 651-454-3174  E-Mail: Scampeau@lifeworks.org  Contact Person: Sherry Campeau | **County Case Manager: Emilie Fisch**  Address: 6328 Penn Avenue S  Richfield, MN 55423  Phone Number: 612-767-5152  Cell:  Fax: 612-767-5176  E-Mail: Emilie.Fisch@Fraser.org | | **County Financial Worker: Team 251**  Maxis #: 14755909  Address:  Phone Number:  Cell:  Fax:  E-Mail: | **Behavioral Analyst: N/A**  Address:  Phone Number:  Cell:  Fax:  E-Mail: | | **Current School/Day Program/Work: N/A**  Address:  Phone:  Fax:  E-mail:  Contact Person: | **Physician: North Clinic**  Address: 3366 Oakdale Ave. N, Suite 215  Robbinsdale, MN 55422  Phone Number: 763-587-7900  Cell:  Fax:  E-Mail: | | **Hospital of Preference: North Memorial Hospital**  Address: 3300 Oakdale Avenue North  Robbinsdale, MN 55422  Phone Number: 763-520-5200  Cell:  Fax:  E-Mail: | **Dentist: N/A**  Address:  Phone Number:  Cell:  Fax:  E-Mail | |
| **HIGH QUALITY SERVICES CONTACTS** |
| **Program Manager: Jill Manthei**  Cell: 612-581-9978  E-mail: [Jill.Manthei@High QualityServices.org](mailto:Jill.Manthei@PinnacleServices.org)  **Program Director: Jessica Reno**  Office: 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](mailto:Jill.Cihlar@PinnacleServices.org)  **Chairman: Nic Thomley**  Phone: 612-977-3110  E-mail: [Nic.Thomley@High QualityServices.org](mailto:Nic.Thomley@PinnacleServices.org) |
| **REVIEW INCIDENT LOG & CORRECTION PLAN** |
| None |
| **SUMMARY OF RELEVANT EVENTS FOR CONSUMER** |
| None |
| **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”: N/A 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  N/A |
| 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. |
| **Description of the person’s status** |
| What is currently important to the person and for the person: It is important to Derrick to listen to 102.5 FM radio station and to go to movies. It is important for him to be supervised in the community to ensure health and safety.  Status of social relationships and natural supports: Family, brothers, mom, and college - MCTC  Recent inclusion and participation in the community: Derrick attends MCTC and woks at the Salvation Army temporarily  New or ongoing opportunities for the development and exercise of functional and age-appropriate skills, decision making and choice, personal advocacy, and communication: Derrick rides the bus independently  Description of relevant behavioral issues: N/A  Description of relevant health issues: None  Other information as requested by the support team, please indicate: None |
| 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: N/A   Indicate what documentation method(s) will be used to monitor and measure changes in the target symptoms: High Quality is not contracted to monitor the symptoms of psychotropic medications. |

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| **SERVICES AND SUPPORTS** |
| Describe the **general and health-related supports** necessary to support this person based upon the *Self-Management Assessment* and the requirements of person centered planning and service delivery:  Derrick will utilize the support of his mother/ guardian to assist him in scheduling medical and dental appointments.  Derrick will utilize the support of his staff and guardian/mother to provide verbal prompts regarding hygiene (for example, flossing) and dressing appropriately for the weather.  Derrick will utilize the support of his staff and guardian/mother to assist in setting the water temperature to prevent burns.  Derrick will utilize the support of staff and his mother/guardian to be supervised in the community at all times. Derrick has a history of swearing in public, get excessively quiet and at times may not respect others space. In the past, Derrick has also stolen from others.  Derrick may not seek assistance if lost or in an emergency situation. Derrick may become extremely quiet in emergency situations. Derrick may not report injury or illness to others in a timely manner. Derrick may not seek medical assistance or attend to his own medical concerns.  Derrick has a history of leaving and not informing others where he is going. |
| The scope of the services to be provided to support the person’s daily needs and activities include: Derrick requires a staff to meet with him on a monthly basis every second Sunday of the month. |
| Can this person use **dangerous items or equipment**?  Yes  No  If yes, address any concerns or limitations: |
| The person’s **preferences for how services and supports are provided**: Derrick requires a staff who will assist him with trying new community activities and communicating to others using more than one word answers. |
| 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?    Derrick will meet with his support team annual to ensure the coordination of services.  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: Lealer Mallory-Wiggins**  Address: 2766 McNair Drive  Robbinsdale, MN 55422  Phone Number: 763-529-4243  E-Mail: raiscinkids@q.com  **Residential Provider: Lifeworks Personal Support**  Address: 2965 Lone Oak Drive, Suite 160  Eagan, MN  Phone Number: 651-454-2732  Fax: 651-454-3174  E-Mail: Scampeau@lifeworks.org  Contact Person: Sherry Campeau  **County Case Manager: Emilie Fisch**  Address: 6328 Penn Avenue S  Richfield, MN 55423  Phone Number: 612-767-5152  Fax: 612-767-5176  E-Mail: Emilie.Fisch@Fraser.org |
| 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): N/A   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): N/A   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: 10/23/2015  Meeting Attendance: Lealer Mallory-Wiggins, Emilie Fisch, Jessica Reno, and Jill Manthei  Description of Consumer’s participation in conference process: Derrick wasn’t at the meeting  Review of Guardianship or Conservatorship Status: Lealer Mallory-Wiggins is guardian.  Review of Placement and Appropriateness: Derrick lives in his own apartment and this is appropriate. |
| Other discussion: Lealer discussed staffing issues with High Quality and set that the shift will always occur on the same day each month. If there needs to be any rescheduling, Lealer must approve it beforehand. |

**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: |