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| COORDINATED SERVICE AND SUPPORT PLAN (CSSP) ADDENDUM |
| Name of person served: Laura Cooper    Date of development: 02/09/2015  For the annual period from: 02/18/2015 to 02/17/2016  Name and title of person completing the *CSSP Addendum*: Jessica Reno, Program Director  Legal representative: Parents, Debbie and Scott Cooper  Case manager: Kristina Bruggeman-Maag  Other support team members: Ann Lewis  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: Laura Cooper  DOB: 08/04/1977  Sex: Female  Weight: 98lbs  Eye Color: Hazel  Race: Caucasian  Height: 4’7”  Hair Color: Brown | Address: 5125 Porter Ave. #210  Minnetonka, MN 55345  Phone: 952-474-5568  Religious Preference: Jewish | |
| **SERVICE DATA** |
| Intake Date: 09/04/2001  Legal Status: Laura’s parents, Debbie and Scott Cooper are her guardians.  Service Initiation Date: 09/04/2001  County of Financial Responsibility: Hennepin  County of Service Responsibility: Hennepin |
| **FINANCIAL RESOURCES** |
| Social Security Number: 472-98-0173  Medical Assistance Number: 01784375  Medicare Number:  Type: SSI, wages  Amount/Month:  Savings Account Balance: Financial Institution:  Checking Account Balance: Financial Institution:  Burial Account Balance: Financial Institution: |
| **CLIENT SPECIFIC INFORMATION** |
| Mobility: Laura is ambulatory but requires staff assistance when navigating uneven terrain to avoid falls.  Use of Public Transportation: Laura utilizes Metro Mobility and cabs for transportation.  Self-Cares: Independent  Domestic: Semi- Independent  Eating: Independent  Primary Mode of Communication: Verbal  Adaptive Equipment or Appliances: Laura utilizes glasses to assist with seeing distances far away.  Is able to drink alcohol? No  Identify form of Personal Identification (card, bracelet, necklace...) State ID |
| **DESCRIBE CONSUMER INTERESTS** |
| Laura enjoys attending empowerment group as well as activates at the Jewish Community Center. Laura love to travel and has been on many vacations around the world. |
| **HEALTH INFORMATION** |
| **Diagnosis**: Laura is diagnosed with Mild MR, Williams Syndrome, Barrett’s Esophagus, Super Vascular Tachycardia, Mitral Valve Inefficiency, Osteoporosis and extreme sensitivity to loud noises.  For Training Purposes- Williams syndrome (WS) is a genetic condition that is present at birth and can affect anyone.  It is characterized by medical problems, including cardiovascular disease, developmental delays, and learning disabilities. These occur side by side with striking verbal abilities, highly social personalities and an affinity for music.  **Seizures**: No  **Protocol on file**: None |
| Current Prescription Medications:   |  |  |  |  | | --- | --- | --- | --- | | **Medication:** | **Dosage:** | **Time:** | **Reason:** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |
| **Allergies:** Laura is allergic to Omnipaque.  **Special Diet:** Laura is lactose, fructose, and gluten intolerant. Laura cannot eat sugar, this includes carbs. Laura also Barrett’s Disease, a severe form of acid reflex disorder. Staff will give verbal reminders about appropriate foods and her nutritional plan. |
| **CONSUMER CONTACTS / LICENSE HOLDERS** |
| |  |  | | --- | --- | | **Emergency Contact Person(s):** Debbie and Scott Cooper  Address: 1040 Bayside Lane  Minnetrista, MN 55364  Phone Number: 952-472-0187  Cell: 612-616-0470 Debbie, 612-369-1567 Scott  Fax:  E-Mail: mom12051@aol.com | **Family Choice of Alternate Emergency Contact:** Michael Cooper, brother  Address: 6489 Westchester Circle  Golden Valley, MN  Phone Number: 612-369-2780  Cell:  Fax:  E-Mail: | | **Residential Provider:** Frasier, Excelsior Court  Address: 5125 Porter Ave.  Wayzata , MN 55391  Phone Number:  Cell:  Fax: 952-473-8629  E-Mail:  Contact Person: | **County Case Manager:** Kristina Bruggeman-Maag  Address: 1909 East Wayzata Blvd. Wayzata, MN 55391  Phone Number: 952-277-2475  Cell:  Fax: 952-473-8629  E-Mail: KBruggemman-Maag@hammer.org | | **County Financial Worker:**  Address:  Phone Number:  Cell:  Fax:  E-Mail: | **Behavioral Analyst:**  Address:  Phone Number:  Cell:  Fax:  E-Mail: | | **Day Program/Work:** eQuality Pathways to Potential  Address: 3717 Colgate Avenue  Minneapolis, MN 55410  Phone: 763-291-7428  Fax:  E-mail: ann@equalityonline.org  Contact Person: Ann Lewis | **Physician:** Dr. Wang, Allina Medical Clinic  Address: 825 Nicollet Mall Suite 300  Minneapolis, MN 55401  Phone Number: 612-333-8883  Cell:  Fax:  E-Mail: | | **Hospital of Preference:** Abott Northwestern  Address: 800 East 28th Street  Minneapolis, MN  Phone Number: 612-863-4000  Cell:  Fax:  E-Mail: | **Dentist:**  Address:  Phone Number:  Cell:  Fax:  E-Mail | | **Other:** (Psychologist, Psychiatrist, Neurologist, OT, PT, Speech, etc.) |  | |
| **HIGH QUALITY SERVICES CONTACTS** |
| **Program Manager: Michelle Schneider**  Direct: 612-977-3102  Cell: 612-384-5876  E-mail: [Michelle.Schneider@High QualityServices.org](mailto:Michelle.Schneider@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](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** |
| Laura recently traveled on a cruise. |
| **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”: If Laura becomes sick during in-home support hours, Laura will need to be taken to the nearest Urgent Care location and call her parents to let them know. 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. |
| **Description of the person’s status** |
| What is currently important to the person and for the person: It is important to Laura to be socially active and have harmonious relationships with others. It is important for Laura to maintain her physical health and maintain her level of independence and safety in the community.  Status of social relationships and natural supports: Laura is very social and has a strong natural support system which includes family, friends, and peer groups.  Recent inclusion and participation in the community: Laura actively participates in an Empowerment Group through Resource Inc. as well as a series of activities at the Jewish Community Center. Laura is currently working in the community through eQuality Pathways to Potential.  New or ongoing opportunities for the development and exercise of functional and age-appropriate skills, decision making and choice, personal advocacy, and communication: Laura utilizes self-advocacy skills in her Empowerment Group and has reported an interest in attending counseling.  Description of relevant behavioral issues: None  Description of relevant health issues: Laura is continuing to increase healthy lifestyle choices by attending personal training and nutritionist sessions at Lifetime Fitness. Laura and her High Quality staff also work on a weekly basis on healthy meal choices and tracking her Wight Watchers points.  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:   Indicate what documentation method(s) will be used to monitor and measure changes in the target symptoms: |

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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:  Laura needs help identifying when medical treatment is needed, making appointments, and obtaining transportation to appointments. Laura’s parents support Laura in arranging medical appointments. Laura does need support getting to the appointments and help Laura’s obtain her prescriptions for her if requested. If Laura becomes sick in the presence of in-home staff, Laura will need to be taken to the nearest Urgent Care location and call her parents to let them know.  If Laura starts to feel a rapid heartbeat, Laura’s parents will be called immediately. Laura is instructed to push like she is using the bathroom to stop the rapid heartbeats. If the condition continues and Laura’s parents cannot be reached 911will be called and wait for an ambulance to arrive. |
| The scope of the services to be provided to support the person’s daily needs and activities include:  Laura will be assisted with grocery shopping every few days. Laura’s mom would like staff to inform her how much Laura spends while grocery shopping to ensure there is enough in her bank account. Laura will have assistance in going through her refrigerator and throwing any food that has gone bad. Laura will plan to cook and eat in her apartment more than eating out. Laura also will limit the amount of pop she drinks when with IHS staff. Staff will prompt Laura to try to only drink diet coke, coke zero and water. |
| 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**:  Laura prefers staff who are accepting, non-threatening and supportive. Laura needs staff who are supportive, informational and use a coaching and directional approach. |
| 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?    Laura and her team will meet semi-annually to coordinate service provision and ensure a continuity of care.  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:   |  |  | | --- | --- | | **Emergency Contact Person(s):** Debbie and Scott Cooper  Address: 1040 Bayside Lane  Minnetrista, MN 55364  Phone Number: 952-472-0187  Cell: 612-616-0470 Debbie, 612-369-1567 Scott  Fax:  E-Mail: mom12051@aol.com | **Family Choice of Alternate Emergency Contact:** Michael Cooper, brother  Address:  Phone Number: 612-369-2780  Cell:  Fax:  E-Mail: | | **Residential Provider:** Frasier  Address: 5125 Porter Ave.  Wayzata , MN 55391  Phone Number: 952-277-2475  Cell:  Fax: 952-473-8629  E-Mail:  Contact Person: Melissa Lowe | **County Case Manager:** Kristina Bruggeman-Maag  Address: 1909 East Wayzata Blvd. Wayzata, MN 55391  Phone Number:  Cell:  Fax: 952-473-8629  E-Mail: KBruggemman-Maag@hammer.org | | **Day Program/Work:** eQuality Pathways to Potential  Address: 3717 Colgate Avenue  Minneapolis, MN 55410  Phone: 763-291-7428  Fax:  E-mail: ann@equalityonline.org  Contact Person: Ann Lewis |  | |
| 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: 02/28/2015  Meeting Attendance: Debbie Cooper, Laura Cooper, Kristina Bruggeman-Maag, Ann Lewis, Jessica Reno  Description of Consumer’s participation in conference process: Laura was quiet during the meeting and was observed as repeatedly wringing her hands due to anxiety. When asked direct questions Laura answered and advocated for herself well.  Review of Guardianship or Conservatorship Status: Appropriate at this time.  Review of Placement and Appropriateness: Appropriate at this time, however the team discussed that as Laura ages and her healthy might decline an alternative housing placement would need to be secured. |
| Other discussion: Laura and her case worker through eQuality Pathways to Potential discussed that a health initiative at her job site would be implanted. Laura became upset after hearing that snacks would have to be approved by the supervisor and that water intake would be monitored. Laura reported, “well maybe I do not want to work there any more” and then apologized that her statement was said of frustration. |

**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: |