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| COORDINATED SERVICE AND SUPPORT PLAN (CSSP) ADDENDUM |
| Name of person served: Adeibyi Adekola    Date of development: 11/16/2015  For the annual period from: \_\_\_3/27/2014\_\_\_\_ to \_\_\_\_3/26/2015\_\_\_\_\_\_  Name and title of person completing the *CSSP Addendum*: Jill Manthei, Program Coordinator  Legal representative: Kehinde Adekola & Kola Adekola  Case manager: Ellen Gabrielson  Other support team members: Jill Manthei, IHS staff, Jessica Reno, Sam Ofulue/Mona Patterson  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: Adeibyi Adekola  DOB: 6/15/1985  Sex: Male  Weight: 190lbs  Eye Color: Black  Race: African  Height: 6’0  Hair Color: Black | Address: 629 73rd Way North  Brooklyn Park, MN 55444  Phone: 763-561-2841  Religious Preference: Unknown | |
| **SERVICE DATA** |
| Intake Date: September 11, 2009  Legal Status: Parents are legal guardians.  Service Initiation Date: September 11, 2009  County of Financial Responsibility: Hennepin  County of Service Responsibility: Hennepin |
| **FINANCIAL RESOURCES** |
| Social Security Number: 475-06-0396  Medical Assistance Number: 00112090  Medicare Number: N/A  Type: (MSA, RSDI, SSI, wages): Unknown  Amount/Month: Unknown  Savings Account Balance: Unknown Financial Institution: Unknown  Checking Account Balance: Unknown Financial Institution: Unknown  Burial Account Balance: Unknown Financial Institution: Unknown |
| **CLIENT SPECIFIC INFORMATION** |
| Mobility: Independent  Use of Public Transportation: Semi-Dependent  Self-Cares: Independent  Domestic: Semi-Independent; requires prompts.  Eating: Independent  Primary Mode of Communication: Verbal  Adaptive Equipment or Appliances: No  Is able to drink alcohol? No  Identify form of Personal Identification (card, bracelet, necklace...) State Identification. |
| **DESCRIBE CONSUMER INTERESTS** |
| Adeibyi enjoys listening to music, the State Fair, Mall of America, the Science Museum, travelling, singing, bowling and playing basketball. Adeibyi also enjoys going to Northtown Mall and Cheapo. |
| **HEALTH INFORMATION** |
| **Diagnosis**: Autism  **Seizures**: N/A  **Protocol on file**: N/A |
| Current Prescription Medications:   |  |  |  |  | | --- | --- | --- | --- | | **Medication:** | **Dosage:** | **Time:** | **Reason:** | | **None** |  |  |  | |  |  |  |  | |  |  |  |  | |
| |  | | --- | | **Allergies:** NKA  **Special Diet:** No specific diet restrictions. | |
| **CONSUMER CONTACTS / LICENSE HOLDERS** |
| |  |  | | --- | --- | | **Parents: Kehinde Adekola and Kola Adekola**  Address: 629 73rd Way North  Brooklyn Park MN 55444  Phone Number: 763-561-2841  Cell: 612-598-5237 (Kehinde)  612-598-5364 (Kola)  Fax: N/A  E-Mail: [kasca4@gmail.com](mailto:kasca4@gmail.com) | **Family Choice of Alternate Emergency Contact: Lanre Adekola**  Address: New York  Phone Number: 612-598-5408  Cell: 612-598-5366  Fax: N/A  E-Mail: N/A | | **Family Choice of Alternate Emergency Contact: Omolara Adekola**  Address: 629 73rd Way North  Brooklyn Park MN 55444  Phone Number: 612-588-4668  Cell: 612-598-5366  Fax: N/A  E-Mail: N/A | **Parents: Kehinde Adekola and Kola Adekola**  Address: 629 73rd Way North  Brooklyn Park MN 55444  Phone Number: 763-561-2841  Cell: 612-598-5237 (Kehinde)  612-598-5364 (Kola)  Fax: N/A  E-Mail: kasca4@gmail.com | | **Legal Representative: Kehinde Adekola and Kola Adekola**  Address: 629 73rd Way North  Brooklyn Park MN 55444  Phone Number: 763-561-2841  Cell: 612-598-5237 (Kehinde); 612-598-5364 (Kola)  Fax: N/A  E-Mail: kasca4@gmail.com | **County Case Manager: Ellen Gabrielson**  Address: 9600 Aldrich Avenue South  Mail Code 658  Bloomington, MN 55420  Phone Number: 612-348-8810  Cell: N/A  Fax: 612-466-9631  E-Mail: ellen.gabrielson@hennepin.us | | **County Financial Worker: Economic Assistance HSPH Team #10 case #42220**  Address: N/A  Phone Number: 612-596-1300  Cell: N/A  Fax: N/A  E-Mail: N/A | **Behavioral Analyst:**  Address:  Phone Number:  Cell:  Fax:  E-Mail: | | **Current School/Day Program/Work: e quality Pathways to Potential**  Address: 3717 Colgate Avenue  Minneapolis, MN 55410  Phone: 612-232-3644/763-479-3014  Fax: N/A  E-mail: sam@equalityonline.org  Contact Person: Samuel Ofulue, Program Coordinator/Mona Patterson | **Physician: Dr. Mulhan, Riverside Family Physicians**  Address: 606 24th Avenue South  Minneapolis, MN  Phone Number: 612-672-2450  Cell: N/A  Fax: N/A  E-Mail: N/A | | **Hospital of Preference: Riverside Family Physicians**  Address: 606 24th Avenue South  Minneapolis, MN  Phone Number: 612-672-2450  Cell: N/A  Fax: N/A  E-Mail: N/A | **Dentist: Brooklyn Park Dental**  Address: 6437 Brooklyn Blvd  Brooklyn Center, MN  Phone Number: 763-781-7475  Cell: N/A  Fax: N/A  E-Mail: N/A | | **Medica Care Coordinator: Denise Burlager**  Address: Mail Route CP340, 401 Carlson Parkway, Minnetonka, MN 55305  Phone Number: 952-992-3864  Fax: N/A  E-Mail: denise.burlager@medica.com |  | |
| **HIGH QUALITY SERVICES CONTACTS** |
| **Program Manager: Jill Manthei**  Cell: 612-581-9978  Office: 612-500-9203  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  **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) |
| **REVIEW INCIDENT LOG & CORRECTION PLAN** |
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| **SUMMARY OF RELEVANT EVENTS FOR CONSUMER** |
| Adeibyi continues to work at the Maple Grove Holiday Inn and Suites on a weekly basis. |
| **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  Not Applicable |
| 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:  Status of social relationships and natural supports:  Recent inclusion and participation in the community:  New or ongoing opportunities for the development and exercise of functional and age-appropriate skills, decision making and choice, personal advocacy, and communication:  Description of relevant behavioral issues:  Description of relevant health issues  Other information as requested by the support team, please indicate: |
| 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 track symptoms of psychotropic mediations. |

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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:  Adeibyi has spring allergies.  High Quality staff will not administer medications. If Adebiyi were prescribed any medications his guardians would assist him taking the medications.  Adebiyi may not always report illness or injury to staff. Adebiyi may not always seek assistance and may not be able to provide for his own medical concerns.  Adebiyi’s guardians arrange and schedule all medical appointments and manage his healthcare needs.  Adebiyi will utilize the support of staff to provide a verbal prompt, asking Adebiyi to withdraw no more than $20 dollars from the ATM during In Home Service shifts. AA will also utilize the support of staff to provide a verbal prompt, asking Adebiyi to save receipts to account for the money he spends during In Home Services shifts. All receipts will be clipped to Adebiyi’s notebook for Kehinde to reference. |
| The scope of the services to be provided to support the person’s daily needs and activities include: High Quality staff will maintain supervision of Adebiyi while in the community completing In Home Services shifts. |
| 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**:  Adeibyi must be notified in advance of any upcoming activities or events. |
| 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?  All concerns, questions or incident reports will be reported to the team in a timely manner. The team will also be notified of any changes in services (service charges, sources of funding, staff, limits to services etc…).  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:  **Kehinde Adekola and Kola Adekola**  Phone Number: 763-561-2841  Cell: 612-598-5237 (Kehinde)  612-598-5364 (Kola)  **Ellen Gabrielson**  Phone Number: 612-348-8810 |
| 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 requiements 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):  Not Applicable   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):  Not Applicable   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: 11/19/2015  Meeting Attendance: Kehinde Adekola, Adebiyi Adekola, Ellen Gabrielson, Samuel Ofulue, Jill Manthei  Description of Consumer’s participation in conference process: Adebiyi talked a lot for the part of the meeting he was in attendance for. He was unable to stay the whole meeting due to having to get back to work with his job coach. He shared what he like about both his job and ILS.  Review of Guardianship or Conservatorship Status: Guardianship is appropriate at this time.  Review of Placement and Appropriateness: Guardianship is appropriate at this time |
| Other discussion: |

**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: |