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| COORDINATED SERVICE AND SUPPORT PLAN (CSSP) ADDENDUM |
| Name of person served: Aaron Kitchener    Date of development: 08/11/2014  For the annual period from 10/1/14 to 10/1/15  Name and title of person completing the *CSSP Addendum*: Arianna Larsen, Program Coordinator  Legal representative: Aaron Kitchener  Case manager: Becky Nye  Other support team members: Johanna Geurkink, Jessica Reno, John and Christine Kitchener  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 several items listed in this addendum. * Within 20 working days of the 45-day meeting, this addendum must be signed and dated by the person served and/or legal representative and case manager to document completion and approval. * Annually, the support team reviews the *Coordinated Services and Support Plan Addendum.* * Within 10 working days of the progress review meeting, this addendum must also be signed and dated by the person served and/or legal representative and case manager to document completion and approval. |

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| **CLIENT IDENTIFYING INFORMATION** |
| |  |  | | --- | --- | | Consumer Name: Aaron Kitchener  DOB:9-11-1992  Sex: Male  Weight: 205lbs  Eye Color: Brown  Race: Caucasian  Height: N/A  Hair Color: Brown | Address: 8617 Edinbrook Crossing, Apt. 244  Brooklyn Park, MN  Phone: 612-412-6020  Religious Preference: Jewish | |

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| **SERVICE DATA** |
| Intake Date: 8/15/14  Legal Status: Own guardian.  Service Initiation Date: 8/15/14  County of Financial Responsibility: Hennepin County  County of Service Responsibility: Hennepin County |

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| **FINANCIAL RESOURCES** |
| Social Security Number: 475-25-0121  Medical Assistance Number: 04488922  Medicare Number: NA  Type: (MSA, RSDI, SSI, wages): SSDI  Amount/Month: $877/month  Savings Account Balance: N/A Financial Institution: N/A  Checking Account Balance: N/A Financial Institution: N/A  Burial Account Balance: N/A Financial Institution: N/A |

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| **CLIENT SPECIFIC INFORMATION** |
| Mobility: Independent  Use of Public Transportation: Independent, uses Metro Mobility.  Self-Cares: Semi-Independent, requires prompts and reminders.  Domestic: Semi-Independent, requires prompts and reminders.  Eating: Independent  Primary Mode of Communication: Verbal  Adaptive Equipment or Appliances: Uses glasses when in a classroom.  Is able to drink alcohol? Has occasional beer.  Identify form of Personal Identification (card, bracelet, necklace...) State Identification |

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| **DESCRIBE CONSUMER INTERESTS** |
| Aaron enjoys writing, working, sports (golf, basketball and football) and eating out. |

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| **HEALTH INFORMATION** |
| **Diagnosis**: Schizoaffective Disorder  **Seizures**: N/A  **Protocol on file**: N/A |
| Current Prescription Medications:   |  |  |  |  | | --- | --- | --- | --- | | **Medication:** | **Dosage:** | **Time:** | **Reason:** | | **Risperdal** | **4mg** | **4mg every night** |  | | **Lexapro** | **10mg** | **10 mg once daily** |  | | **Lithium** | **900 mg (2 450mg tablets)** | **Once daily at nighttime** |  | | **Olanzapine** | **20mg** | **Once daily at nighttime** |  | | **Trazodone** | **200mg (2 100 mg tablets)** | **Once daily as needed at night** | **Sleep** | |
| **Allergies:** Penicillin and Clozaril.  **Special Diet:** Aaron will limit junk food intake. |

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| **CONSUMER CONTACTS / LICENSE HOLDERS** |
| |  |  | | --- | --- | | **Emergency Contact Person(s): John and Christine Kitchener**  Address:  Phone Number:  Cell: 612-272-0167 (Christine); 952-261-9363 (John)  Fax: N/A  E-Mail: [jkmagnetic@gmail.com](mailto:jkmagnetic@gmail.com) ( John)  [cclarkstyle@gmail.com](mailto:cclarkstyle@gmail.com) (Christine) | **Family Choice of Alternate Emergency Contact: Glen Baron (Family Friend)**  Address: N/A  Phone Number: 612-759-1278  Cell: N/A  Fax: N/A  E-Mail: N/A | | **Legal Representative: Aaron Kitchener**  Address: 8617 Edinbrook Crossing, Apt. 244  Brooklyn Park, MN  Phone Number: N/A  Cell: 612-412-6020  Fax: N/A  E-Mail: N/A | **Parents: John and Christine Kitchener**  Address: 808 Mount Curve Ave  Minneapolis, MN 55403  Phone Number: N/A  Cell: 612-272-0167 (Christine); 952-261-9363 (John)  Fax: N/A  E-Mail:[jkmagnetic@gmail.com](mailto:jkmagnetic@gmail.com) | | **Residential Provider: High Quality Services**  Address: 8617 Edinbrook Crossing  Phone Number: 763-657-0612  Cell: 612-749-2003  Fax: 763-273-4979  E-Mail: johanna.geurkink@High Qualityservices.org  Contact Person: Johanna Geurkink | **County Case Manager: Becky Nye**  Address: 1800 Chicago Avenue  Minneapolis, MN 55404  Phone Number: 612-879-3527  Cell: N/A  Fax: 612-321-3821  E-Mail: [Becky.Nye@hennepin.us](mailto:Becky.Nye@hennepin.us) | | **County Financial Worker: N/A**  Address:  Phone Number:  Cell:  Fax:  E-Mail: | **Behavioral Analyst: NA**  Address:  Phone Number:  Cell:  Fax:  E-Mail: | | **Psychologist: Associated Clinic of Psychology, Julie Malmberge**  Address:  Phone Number: 612-725-6033 (Main Office)  612-388-3103 (Direct Line)  Fax: N/A  E-mail: N/A | **Physician: Dr. Mark Schmidt-Allina Health Clinic**  Address: 2855 Campus Drive #400  Plymouth, MN  Phone Number: 763-577-7400  Cell: N/A  Fax: 763-236-2650  E-Mail: N/A | | **Hospital of Preference: Fairview University Medical Center**  Address: 2450 Riverside Avenue  Minneapolis, MN 55454  Phone Number: 612-273-3000  Cell: N/A  Fax: N/A  E-Mail: N/A | **Dentist: Dr. Bob Hanson**  Address: Near Ridgedale in Minnetonka.  Phone Number:  Cell: N/A  Fax: N/A  E-Mail: N/A | | **Psychiatrist: Dr. Kruse, Fairview Primary Clinic:**  Address: 606 24th Ave S, Suite 602  Minneapolis, MN 55454  Phone Number: 612-273-4494  Fax: N/A  E-mail: N/A | **Therapist: Ben Von Ende, Fairview Primary Clinic**  Address: 4000 Central Avenue, NE  Columbia Heights, MN 55421  Phone Number: 612-272-6999  Cell: N/A  Fax: N/A  E-Mail: N/A | |

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| **HIGH QUALITY SERVICES CONTACTS** |
| **Program Manager: Arianna Larsen**  Cell: 612-384-5764  Office: 612-977-3116  E-mail: arianna.larsen@High Qualityservices.org  **Program Director: Jessica Reno**  Phone: 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) |

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| **REVIEW INCIDENT LOG & CORRECTION PLAN** |
| Aaron was evicted from his apartment for gaining unlawful entrance into his neighbor’s apartment. Aaron also physically aggressed towards his father in the emergency room at Fairview University Medical Center. At this hospital, Aaron also struck another patient. |

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| **SUMMARY OF RELEVANT EVENTS FOR CONSUMER** |
| Aaron worked at Como Zoo, a hockey rink and a general store in his neighborhood. Aaron also was a soccer referee. |

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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.  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:  Aaron will need a staff who encourages him to maintain a sober and healthy lifestyle, obtain employment and find positive role models in his life. Aaron’s staff must encourage him to limit eating out & junk food and to work out on a regular basis. |
| 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 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 to the person’s physician or prescriber. * 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 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.Does the person use prescribed psychotropic medication?  Yes  No  Not Applicable |
| 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:  Description of Relevant Behavioral Issues: |

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| **PERSON CENTERED OUTCOMES** |
| The license holder must provide services in response to the person’s identified needs, interests, preferences, and desired outcomes. Services will be provided according to MN Statutes, chapter 245D and the applicable waiver plan for the person served. The following information will be assessed and determined by the person served and/or legal representative and case manager and other members of the support team. |
| The **scope of the services** to be provided to support the person’s daily needs and activities include:  Aaron will meet with his staff 3 hours per week. Aaron will work on working out, eating healthy and maintaining a drug free lifestyle. Aaron will work on outcomes which focus on becoming more independent, budgeting, cleaning and establishing a daily routine. |
| **Outcome #1: I would like to work on becoming more independent by becoming familiar with the surrounding area. This will include getting to know the bus route. I will plan out my weekly activities and then write them down in my planner with assistance from my ILS worker at least 50% of the time until December 2014.**  **Date of development: 9/25/14**  **Projected start date for implementation: October 2014**  **Date by which progress towards accomplishing the outcome will be reviewed and evaluated: December 2014** |
| Outcome statement with measurable and observable criteria for outcome achievement:  I would like to work on becoming more independent by becoming familiar with the surrounding area. This will include getting to know the bus route. I will plan out my weekly activities and then write them down in my planner with assistance from my ILS worker at least 50% of the time until January 2015. |
| Methods or actions that will be used to support the person and to accomplish the outcome:  Aaron will need staff to be supportive and encouraging. |
| Changes or modifications necessary to the physical and social environments:  Aaron will need to work more on his organizational techniques with his ILS staff. |
| Equipment and/or materials required:  Knowledge of bus route and surrounding area, planner, Community Education guide, knowledge of community activities, Jewish Community Center Fall Guide, Hennepin Tech Community College Guide. |
| Techniques that are used that are consistent with the person’s communication mode:  Aaron requires a staff who is verbal and capable of communicating to him future commitments. |
| Techniques that are used that are consistent with the person’s learning style:  Aaron will need reminders and prompting to work on this outcome. Aaron will also need staff who can help assist with tracking his daily and weekly commitments. |
| Data collection method:  This outcome from the data will be documented in weekly shift summaries and reviewed by the Program Coordinator on a weekly basis. |
| Names of staff or positions responsible for implementing the supports and methods:  Aaron, ILS staff, Program Coordinator, Program Director. |
| **DATA COLLECTION KEY** |
| \*Summarize Performance toward Outcome using documentation from daily log and make recommendations using the following key. Be sure to include the measurement criteria in the summary to determine if progress has been made on the goal. |
| |  |  |  |  | | --- | --- | --- | --- | | Month & Year | Percentage | A= Accomplished  MP= Made Progress  LP= Little Progress  NP =No Progress | Comments | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |
| **Outcome #2: I would like to work on obtaining employment. I will work on my resume and cover letter with assistance from my ILS staff and outside resources like the library and workforce centers. I will work on obtaining employment at least 50% of the time until December 2014.**  **Date of development: 9/25/14 ( revisions made 10/09/14)**  **Projected start date for implementation: October 2014**  **Date by which progress towards accomplishing the outcome will be reviewed and evaluated: December 2014** |
| Outcome statement with measurable and observable criteria for outcome achievement:  I would like to work on obtaining employment. I will work on my resume and cover letter with assistance from my ILS staff and outside resources like the library and workforce centers. I will work on obtaining employment at least 50% of the time until January 2015. |
| Methods or actions that will be used to support the person and to accomplish the outcome:  Aaron will need staff to be supportive and encouraging. |
| Changes or modifications necessary to the physical and social environments:  Aaron will spend time at the Library and Workforce centers in order to increase his chances of obtaining employment. |
| Equipment and/or materials required:  Resume, Cover Letter, Library, Workforce Centers, employers that are hiring, pen, paper, and applications. |
| Techniques that are used that are consistent with the person’s communication mode:  Aaron requires a staff who is verbal and able to remind him of his responsibilities in looking for employment. |
| Techniques that are used that are consistent with the person’s learning style:  Aaron will need verbal reminders and prompts in staying on track during the application process. Aaron may need assistance with being organized to successfully complete this outcome. |
| Data collection method:  This outcome from the data will be documented in weekly shift summaries and reviewed by the Program Coordinator on a weekly basis. |
| Names of staff or positions responsible for implementing the supports and methods:  Aaron, ILS staff, Program Coordinator, Program Director. |
| **DATA COLLECTION KEY** |
| \*Summarize Performance toward Outcome using documentation from daily log and make recommendations using the following key. Be sure to include the measurement criteria in the summary to determine if progress has been made on the goal. |
| |  |  |  |  | | --- | --- | --- | --- | | Month & Year | Percentage | A= Accomplished  MP= Made Progress  LP= Little Progress  NP =No Progress | Comments | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |
| **Outcome #3: I will work on maintaining a clean apartment by creating a weekly chore list (washing dishes, vacuuming, washing the floors etc…) with help from my ILS staff. I will clean my apartment 3 days a week based on the cleaning list 50% of the time until December 2014.**  **Date of development: 9/25/14**  **Projected start date for implementation: October 2014**  **Date by which progress towards accomplishing the outcome will be reviewed and evaluated: December 2014** |
| Outcome statement with measurable and observable criteria for outcome achievement:  I will work on maintaining a clean apartment by creating a weekly chore list (washing dishes, vacuuming, washing the floors etc…) with help from my ILS staff. I will clean my apartment 3 days a week based on the cleaning list 50% of the time until January 2015. |
| Methods or actions that will be used to support the person and to accomplish the outcome:  Aaron will need staff to be supportive and encouraging. |
| Changes or modifications necessary to the physical and social environments:  The cleaning list will need to be posted in a visible spot for Aaron. |
| Equipment and/or materials required:  Weekly chore list, cleaning supplies (mop, broom, vacuum, all purpose cleaner etc…) |
| Techniques that are used that are consistent with the person’s communication mode:  Aaron requires a staff who is verbal and able to communicate to him the responsibilities (keeping the living space clean) he has due to sharing an apartment with his roommate. |
| Techniques that are used that are consistent with the person’s learning style:  Aaron may need reminders to complete his weekly chores. He will also may require prompts to stay on top of his chore list. |
| Data collection method:  This outcome from the data will be documented in weekly shift summaries and reviewed by the Program Coordinator on a weekly basis. |
| Names of staff or positions responsible for implementing the supports and methods:  Aaron, ILS staff, Program Coordinator, Program Director. |
| **DATA COLLECTION KEY** |
| \*Summarize Performance toward Outcome using documentation from daily log and make recommendations using the following key. Be sure to include the measurement criteria in the summary to determine if progress has been made on the goal. |
| |  |  |  |  | | --- | --- | --- | --- | | Month & Year | Percentage | A= Accomplished  MP= Made Progress  LP= Little Progress  NP =No Progress | Comments | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |
| **Outcome #4: I will work on establishing a daily routine with my ILS staff. This daily routine will include waking up at a reasonable time in the morning, working out, participating in community activities, volunteering and working on obtaining employment 50% of the time until December 2014.**  **Date of development: 9/25/14**  **Projected start date for implementation: October 2014**  **Date by which progress towards accomplishing the outcome will be reviewed and evaluated: December 2014** |
| Outcome statement with measurable and observable criteria for outcome achievement:  I will work on establishing a daily routine with my ILS staff. This daily routine will include waking up at a reasonable time in the morning, working out, participating in community activities and working on obtaining employment 50% of the time until January 2015. |
| Methods or actions that will be used to support the person and to accomplish the outcome:  Aaron will need staff to be supportive and encouraging. Aaron will also need staff to be firm and hold him accountable to this routine. |
| Changes or modifications necessary to the physical and social environments:  Aaron will develop a routine for each day which will enable him to start his day in a productive manner. |
| Equipment and/or materials required:  Alarm clocks, motivation, community activities, employment resources, work out facility, volunteer organizations. |
| Techniques that are used that are consistent with the person’s communication mode:  Aaron requires a staff who is verbal and able to communicate to him the responsibilities of maintaining a daily routine. |
| Techniques that are used that are consistent with the person’s learning style:  Aaron may need reminders to work on his daily routine on a regular basis. He will need reminders to stay focused on the daily routine. |
| Data collection method:  This outcome from the data will be documented in weekly shift summaries and reviewed by the Program Coordinator on a weekly basis. |
| Names of staff or positions responsible for implementing the supports and methods:  Aaron, ILS staff, Program Coordinator, Program Director. |
| **DATA COLLECTION KEY** |
| \*Summarize Performance toward Outcome using documentation from daily log and make recommendations using the following key. Be sure to include the measurement criteria in the summary to determine if progress has been made on the goal. |
| |  |  |  |  | | --- | --- | --- | --- | | Month & Year | Percentage | A= Accomplished  MP= Made Progress  LP= Little Progress  NP =No Progress | Comments | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |

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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. |

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| PERMITTED ACTIONS AND PROCEDURES |
| 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*: |
| 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: |

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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. Frequency of receiving a statement that itemizes receipt and disbursements of funds will be completed as requested on the *Financial Authorization* form. |

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| **CONFERENCE MINUTES (Summary of team discussion/determinations)** |
| Meeting Date: 10/1/14  Meeting Attendance: Aaron, Christine, Johanna, and Becky  Description of Consumer’s participation in conference process: Aaron actively participated in the meeting.  Review of Guardianship or Conservatorship Status: It is appropriate.  Review of Placement and Appropriateness: It is appropriate.  Description of Relevant Health Issues: Aaron’s junk food intake needs to be monitored. |
| Description of Relevant Behavioral Issues: Aaron has physically aggressed towards others. |
| Other discussion: The team discussed outcomes for Aaron. |

**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: |