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| COORDINATED SERVICE AND SUPPORT PLAN (CSSP) ADDENDUM |
| Name of person served: Brenda Overton    Date of development: 10/27/2014  For the annual period from: 4/17/2014 to 5/14/2015  Name and title of person completing the *CSSP Addendum*: Jessica Reno, Program Director  Legal representative: Brenda is her own guardian.  Case manager: Cynthia Carr  Other support team members:  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: Brenda Overton  DOB: 8/25/1954  Sex: Female  Weight: N/A  Eye Color: Dark Brown  Race: African American  Height: 5’7’  Hair Color: Gray/Black | Address: 3101 Aldrich Ave. South  Minneapolis, MN 55408  Phone: 612-822-1550  Religious Preference: Christian | |

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| **SERVICE DATA** |
| Intake Date: 11/4/2009  Legal Status: Brenda is her own guardian.  Service Initiation Date: 11/4/2009  County of Financial Responsibility: Hennepin  County of Service Responsibility: Hennepin |

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| **CLIENT SPECIFIC INFORMATION** |
| Mobility: Ambulatory  Use of Public Transportation: Brenda utilizes Metro Mobility independently.  Self-Cares: Semi-Independent, Brenda wears adult depends for incontinence and needs assistance with medication administration due to inability to swallow pills. Brenda receives bi-weekly injections in place of taking the medication orally.  Domestic: Independent  Eating: Independent  Primary Mode of Communication: Verbal  Adaptive Equipment or Appliances: None  Is able to drink alcohol? Yes  Identify form of Personal Identification (card, bracelet, necklace...) Brenda carries state identification. |

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| **DESCRIBE CONSUMER INTERESTS** |
| Brenda enjoys arts & crafts, playing games (checkers, bingo), bowling, watching TV & movies and visiting family & friends. She enjoys listening to music and attending concerts in the park. She listens to a wide variety of music ranging from jazz to rap. Brenda enjoys going for walks particularly around Bryant Park and Lake Calhoun. She also enjoys going out to eat and would like to learn how to use a computer. |

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| **HEALTH INFORMATION** |
| **Diagnosis**: 295.70 Schizoaffective-Unspecified and Bipolar  **Seizures**: None  **Protocol on file**: NA |
| Current Prescription Medications: Brenda receives Risperdal injections at HCMC as she will choose to not to take the medications if they are in pill form.   |  |  |  |  | | --- | --- | --- | --- | | **Medication:** | **Dosage:** | **Time:** | **Reason:** | | **Risperdal** | **Unknown** | **Risperdal/Injections are given every two weeks.** | **Bipolar and Schizoaffective disorder** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |
| **Allergies:** None  **Special Diet:** None |

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| **CONSUMER CONTACTS / LICENSE HOLDERS** |
| |  |  | | --- | --- | | **Emergency Contact Person(s): Marva Overton (sister)**  Address: 4032 Portland Avenue South  Minneapolis, MN 55407  Phone Number: 612-825-2236  Cell: 612-348-7980  Fax: N/A  E-Mail: N/A | **Family Choice of Alternate Emergency Contact: Maria Gadegbeku (daughter)**  Address: 6804 63rd Avenue N. #201  Brooklyn Park, MN 55428  Phone Number: 651-707-2085/612-559-0461  Work: 612-873-3288  Fax: N/A  E-Mail: N/A | | **Legal Representative: Self**  Address: 3101 Aldrich Ave. South  Minneapolis, MN 55408  Phone: 612-822-1550  Cell: N/A  Fax: N/A  E-Mail: N/A | **Parents: N/A**  Address:  Phone Number:  Cell: N/A  Fax: N/A  E-Mail: N/A | | **Residential Provider: Aldrich Board and Care**  Address: 3101 Aldrich Ave S  Minneapolis, MN 55408  Phone Number: 612-822-1550  Office: 612-825-4488  Fax: N/A  E-Mail: N/A  Contact Person(s): Fay Yaeger & Roberta Smith  (Nurse, works Monday and Wednesday) | **County Case Manager: Cynthia Carr, Hennepin County Eastside Neighborhood Services**  Address: 1700 2nd Street NE MC L701A  Minneapolis, MN 55413  Phone Number: 612-348-2562  Cell: 612-207-2681  Fax: 612-632-8631  E-Mail: Cynthia.carr@co.hennepin.mn.us | | **County Financial Worker: Unknown**  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: HCMC, Ellen Coffee**  Address: 701 Park Avenue North  Minneapolis, MN 55415  Phone Number: 612-873-3000  Cell: N/A  Fax: N/A  E-Mail: N/A | | **Hospital of Preference: HCMC**  Address: 701 Park Avenue North  Minneapolis, MN 55415  Phone Number: 612-873-3000  Cell:  Fax: N/A  E-Mail: | **Dentist: HCMC**  Address: 701 Park Avenue North  Minneapolis, MN 55415  Phone Number: 612-873-3000  Cell:  Fax:  E-Mail | | **Psychiatrist: Barbara Johnson**  Address: HFA Adult Psychiatry Clinic  914 South 8th Street Suite D-1140  Minneapolis, MN  Phone Number: 612-347-2218  Cell:  Fax: 612-373-1859  E-Mail: | **Certified Nurse Practitioner: Mildred Johnson**  Address: N/A  Phone: 612-347-2218 | |

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| **High Quality Services Contacts** |
| **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  **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** |
| No incidents were reported this year. |

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| **SUMMARY OF RELEVANT EVENTS FOR CONSUMER** |
| None at this time. |

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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: Injections for medication | Recall Date: Every 2 weeks. | |

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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 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 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. |

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| 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 |
| Describe the target symptoms the psychotropic medication is to alleviate: Bipolar and Schizoaffective disorder Indicate what documentation method(s) will be used to monitor and measure changes in the target symptoms:  High Quality is not contracted to provide psychotropic medication monitoring. |

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| **Services and supports** |
| 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:   * ILS staff will meet with Brenda every week for 2 hours. * Brenda will receive assistance in daily living skills like: decision making, budgeting, healthy eating, maintaining healthy relationships and participating in more community activities or joining local groups or churches. * ILS staff will communicate any concerns to Brenda’s team. |
| 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:  ILS staff will also work with Brenda by budgeting her money. ILS staff will work with Brenda on saving her money and tracking her daily expenses. ILS staff will encourage limiting how often she goes out to eat each month by offering other free or cheap activities in place of going out to eat.  ILS staff will work with Brenda on keeping track of her daily, weekly and monthly appointments by writing down them on a calendar which ILS staff will create and print out for Brenda. These will be reviewed on a weekly basis with Brenda.  ILS staff will encourage Brenda to eat healthy and remind her of the importance of healthy portions. ILS staff will model healthy eating habits.  ILS staff will provide assistance in decision making. Brenda sometimes become overwhelmed with making a decision and will ask ILS staff to make the decision for her. |
| The person’s **preferences for how services and supports are provided**:  During each shift, ILS staff will leave Brenda’s residence and go out in the community. Brenda enjoys being busy during her shift. ILS staff will take out Brenda out to eat once a month.  Brenda needs assistance in deciding what to do during each shift. ILS staff finds it helpful to offer a couple of choices and then have her decide. This helps Brenda feel less overwhelmed in making a decision. Brenda will often refuse to do an activity that involves interacting with others, for example going to the New Wine Church.  During the winter months, Brenda may require more prompts to go out into the community. |
| 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** serving this person to ensure continuity of care?  Brenda and her team will meet semi-annually to coordinate services 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:   |  |  | | --- | --- | | **Residential Provider: Aldrich Group Home**  Address: 3101 Aldrich Ave S  Minneapolis, MN 55408  Phone Number: 612-822-1550  Office: 612-825-4488  Fax: N/A  E-Mail: N/A  Contact Person(s): Fay Yaeger & Roberta Smith  (Nurse, works Monday and Wednesday) | **County Case Manager: Cynthia Carr, Hennepin County Eastside Neighborhood Services**  Address: 1700 2nd Street NE MC L701A  Minneapolis, MN 55413  Phone Number: 612-348-2562  Cell: 612-207-2681  Fax: 612-632-8631  E-Mail: Cynthia.carr@co.hennepin.mn.us | |
| 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. |
| 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: 5/14/2015  Meeting Attendance: Brenda Overton, Consumer; Cynthia Carr, Hennepin County Eastside Neighborhood Services; Lynn Morris, High Quality Services Program Manager  Description of Consumer’s participation in conference process: Brenda participated fully throughout this review meeting. She expressed concerns, asked questions and gave her opinion when appropriate.  Review of Guardianship or Conservatorship Status: Brenda is her own legal guardian.  Review of Placement and Appropriateness: Placement is appropriate at this time.  Description of Relevant Health Issues: Brenda stated that she had been diagnosed with the beginning stages of diabetes. At this time, her doctor did not prescribed any medications or blood glucose level testing. Brenda said that she is doing well with portion control and will continue to work on that in order to help control her diabetes. Brenda has also purchased reading glasses to help with blurriness when reading. |
| Description of Relevant Behavioral Issues: Brenda has had no relevant behavioral issues during this review period. |
| Other discussion:   * Case manager is requesting more information on the activities that Brenda and her staff go on during their visit. Things such as where they went, what they worked on, or any outstanding information. CM has asked that ILS worker call her. * In reviewing Brenda’s goals, Brenda agreed to all suggested changes. * Brenda signed all of the needed documentation. PM reviewed the Rights and Responsibilities with Brenda. |

**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: |