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| COORDINATED SERVICE AND SUPPORT PLAN (CSSP) ADDENDUM |
| Name of person served: Sarah Reardon    Date of development: 12/11/2015  For the annual period from: 12/16/2015 to 45 Day Meeting  Name and title of person completing the *CSSP Addendum*: Jessica Reno, Program Director  Legal representative: Sarah is her own guardian.  Case manager: Abby Dreger  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 areas listed in this addendum. * Annually, the support team reviews the *Coordinated Services and Support Plan Addendum.* |
| **CLIENT IDENTIFYING INFORMATION** |
| |  |  | | --- | --- | | Consumer Name: Sarah Reardon  DOB: 4/30/1963  Sex: Female  Weight: 145lbs  Eye Color: Blue  Race: Caucasian  Height: 5’2”  Hair Color: Blonde | Mailing Address: 35 Marie Ave. Mailbox #7  West St. Paul 55118  Driving Address: 35 Marie Ave. Apt. 35  West St. Paul 55118  Phone: 651-457-1033  Religious Preference: Catholic | |
| **SERVICE DATA** |
| Intake Date:12/16/2015  Legal Status: Sarah is her own guardian.  Service Initiation Date:  County of Financial Responsibility: Dakota County  County of Service Responsibility: Dakota County |
| **FINANCIAL RESOURCES** |
| Social Security Number: 469-92-9173  Medical Assistance Number: N/A  Medicare Number: N/A  Type: RSDI, employment wages  Amount/Month: Sarah reported not wanting to share that information with High Quality at this time.  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 |
| **CLIENT SPECIFIC INFORMATION** |
| Mobility: Ambulatory  Use of Public Transportation: Sarah utilizes transportation support from Allied People’s Solutions for work, ILS staff for appointments, MIK for medical appointments, and Metro Mobility.  Self-Cares: Independent  Domestic: Independent  Eating: Independent  Primary Mode of Communication: Verbal  Adaptive Equipment or Appliances: Bilateral hearing aids and corrective lenses.  Is able to drink alcohol? No  Identify form of Personal Identification (card, bracelet, necklace...) State ID |
| **DESCRIBE CONSUMER INTERESTS** |
| Sarah enjoys working as a part time employee completing secretarial work at the county. Sarah also loves spending time with her family and friends, camping, the 50’s car show at the state fair, and hiking. |
| **HEALTH INFORMATION** |
| **Diagnosis**: 301.83 Borderline Personality Disorder, 269.30 recurring depression, 317 Mild DD, 309.81 PTSD  **Seizures**: None  **Protocol on file**: N/A |
| Current Prescription Medications:   |  |  |  |  | | --- | --- | --- | --- | | **Medication:** | **Dosage:** | **Time:** | **Reason:** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |
| **Allergies:** Sulphur  **Special Diet:** None |
| **CONSUMER CONTACTS / LICENSE HOLDERS** |
| |  |  | | --- | --- | | **Emergency Contact Person(s):** Kathy Reardon, sister  Address:  Phone Number: 651-785-3858  Cell:  Fax:  E-Mail: | **Family Choice of Alternate Emergency Contact:** None Identified  Address:  Phone Number:  Cell:  Fax:  E-Mail: | | **Residential Provider:** N/A  Address:  Phone Number:  Cell:  Fax:  E-Mail:  Contact Person: | **County Case Manager:** Emma Granberry, Meridian Services  Address: 541 Second Ave. S.  Hopkins, MN 55343  Phone Number: 952-999-4702  Cell: N/A  Fax: 952-999-4703  E-Mail: egranberry@meridiansvs.com | | **County Financial Worker:** Amanda Wendt  Address:  Phone Number: 651-554-5765  Cell:  Fax:  E-Mail: | **Behavioral Analyst:** N/A  Address:  Phone Number:  Cell:  Fax:  E-Mail: | | **Current School/Day Program/Work:** Allied People Solutions, Supportive Employment Services  Address: 1885 University Ave. Suite 190  St. Paul, MN 55104  Phone: 651-288-8896, Joan  612-554-6433, Kelly  Fax:  E-mail:  Contact Person: Joan Decker and Kelly | **Physician:** Dr. Punderson, Entira Clinic  Address: 234 East Wentworth Avenue  St. Paul, MN 55118  Phone Number: 651-457-2748  Cell:  Fax: 651-455-3354  E-Mail: | | **Hospital of Preference:** United Hospital  Address: 333 Smith Avenue N  St. Paul, MN 55102  Phone Number: 651-241-8000  Cell:  Fax:  E-Mail: | **Dentist:** Dr. McNamara, Mendota Dental  Address: 111 Riverwood Place  880 Sibley Memorial Highway  Mendota Heights, MN 551118  Phone Number: 651-455-4223  Cell:  Fax:  E-Mail | | **Psychiatrist:** Dr. Charles Gill, Allina Mental Health  Address:  Phone Number: 651-241-5959  Cell:  Fax:  E-Mail: | **ARMHS Worker:** Kristin Ferguson  Address:  Phone Number: 612-720-8548  Cell:  Fax:  E-Mail | |
| **HIGH QUALITY SERVICES CONTACTS** |
| **Program Manager: Liz Notermann**  Cell: 612-418-6343  Office: 612-500-9201  E-mail: [Elizabeth.Notermann@High QualityServices.org](mailto:Elizabeth.Notermann@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  **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** |
| Sarah reported the need to have rotator cuff surgery soon due to a shoulder injury. |
| **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  ILS staff will lock and unlock the medication lock box to support in maintaining safety while Sarah is self-administering her own medication. |
| 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 Sarah to spend time with family and to go camping. It is important for Sarah to maintain her mental health stability by maintaining appointments and medication administration.  Status of social relationships and natural supports: Sarah has a strong familial support network.  Recent inclusion and participation in the community: None  New or ongoing opportunities for the development and exercise of functional and age-appropriate skills, decision making and choice, personal advocacy, and communication: None  Description of relevant behavioral issues: None  Description of relevant health issues: Sarah reported having a bacterial infection in June and now needing to have rotator cuff surgery soon due to a shoulder injury.  Other information as requested by the support team, please indicate: Sarah reviewed with her case manger the need for increase in home support during the recovery from surgery due to limited use of her arm which would limit Sarah’s ability to maintain self-cares. Sarah reported securing after care treatment for several days after surgery and then reported plans to stay with family and utilize in home PCA staff. |
| 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: Depression and anxiety.   Indicate what documentation method(s) will be used to monitor and measure changes in the target symptoms: High Quality is not contracted to monitor target 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:  Sarah is diagnosed with Borderline Personality Disorder, recurring depression, Mild DD, and PTSD. Sarah is aware of the signs and symptoms of these medical conditions and is a strong advocate for her own physical and mental health needs.  Sarah will utilize the support of a skilled nurse that visits her home weekly to set up her medication. Sarah’s medications are housed in a lock box in her home due to a history of self-injurious thoughts regarding medications.  Sarah utilizes independently bilateral hearing aids and corrective lenses.  Sarah has a history of self-injury. Sarah is aware of her mental health symptoms and has a history of self-advocating for mental health needs, including hospitalization. |
| The scope of the services to be provided to support the person’s daily needs and activities include: Sarah will meet with ILS staff on a weekly basis to utilize transportation in the community and maintain organization in regards to billing and money management. |
| Can this person use **dangerous items or equipment**?  Yes  No  If yes, address any concerns or limitations: Sarah’s medications are housed in a lock box in her home due to a history of self-injurious thoughts regarding medications. |
| The person’s **preferences for how services and supports are provided**: Sarah reported learning well from watching someone do something for the first time and then repeating the activity to learn new skills. |
| 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?    Sarah will meet with her support team annually to ensure 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:    **County Case Manager:** Abby Dreger, High Quality Services  Phone Number: 612-977-3976  E-Mail: abby.dreger@High Qualityservices.org  **Allied People Solutions, Supportive Employment Services**  Address: 1885 University Ave. Suite 190  St. Paul, MN 55104  Phone: 651-288-8896  Contact Person: Joan Decker and Kelly |
| 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: 12/16/2015  Meeting Attendance: Sarah Reardon, Abby Dreger, and Jessica Reno  Description of Consumer’s participation in conference process: Sarah actively participated in the meeting by answering questions, telling Jessica about her interests and family, and self-advocating for her support needs in terms of her ILS staffing and upcoming surgery.  Review of Guardianship or Conservatorship Status: Appropriate at this time.  Review of Placement and Appropriateness: Appropriate at this time. |
| Other discussion: Sarah reported needing to have rotator cuff surgery soon due to a shoulder injury. Sarah reviewed with her case manger the need for increase in home support during the recovery from surgery due to limited use of her arm which would limit Sarah’s ability to maintain self-cares. Sarah reported securing after care treatment for several days after surgery and then reported plans to stay with family and utilize in home PCA staff. |

**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: |