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| COORDINATED SERVICE AND SUPPORT PLAN (CSSP) ADDENDUM |
| Name of person served: Mark Offerdahl    Date of development: 7/24/15  For the annual period from: 7/28/15 to 7/27/16  Name and title of person completing the *CSSP Addendum*: Arianna Larsen, Program Manager.  Legal representative: Mark is under the co-guardianship of Karen Offerdahl and Susan Offerdahl.  Case manager: Chris Eck.  Other support team members: Elizabeth Noterman, Arianna Larsen and Jim Ostlund.  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: Mark Offerdahl  DOB: 10/30/1955  Sex: Male  Weight: 190 lb.  Eye Color: Blue  Race: Caucasian  Height: 5’ 11”  Hair Color: Grey | Address: 8617 Edinbrook Crossing, Apt. # 433,  Brooklyn Park, MN 55443  Phone: H.763-657-7134 C: 218-280-1634  Religious Preference: Christian | |
| **SERVICE DATA** |
| Intake Date: 5/28/13  Legal Status: Mark is under the co-guardianship of Karen Offerdahl and Susan Offerdahl  Service Initiation Date: 6/15/13  County of Financial Responsibility: Clearwater  County of Service Responsibility: Hennepin: |
| **FINANCIAL RESOURCES** |
| Social Security Number: 472-72-8050  Medical Assistance Number: 02262468  Medicare Number: N/A  Type: (MSA, RSDI, SSI, wages): SSDI  Amount/Month: $1296.00  Savings Account Balance: NA Financial Institution: NA  Checking Account Balance: NA Financial Institution: NA  Burial Account Balance: NA Financial Institution: NA |
| **CLIENT SPECIFIC INFORMATION** |
| Mobility: Ambulatory.  Use of Public Transportation: Mark uses Metro Mobility as his primary mode transportation; Mark also uses Medi-Van as needed.  Self-Cares: Independent.  Domestic: Semi-Independent, requires direction and cues.  Eating: Independent.  Primary Mode of Communication: Verbal.  Adaptive Equipment or Appliances: Pacemaker or eye glasses.  Is able to drink alcohol? No.  Identify form of Personal Identification (card, bracelet, necklace...) Driver’s License. |
| **DESCRIBE CONSUMER INTERESTS** |
| Mark enjoy staying physically fit and doing activities such as walking, riding bikes, and running. Mark also enjoys going to the library, shopping and going to the Courage center for activities and appointments. Mark has an iPad which he uses for education and leisurely purposes. |
| **HEALTH INFORMATION** |
| **Diagnosis**: Streptococcus mitral endocarditis with mitral and aortic valve insufficiency, stroke, Vitamin D Deficiency, history of multiple myeloma, heart block, osteomyelitis, left popliteal artery occusion, cognitive deficits due to cerebrovascular disease, muscle weakness, aphasia, prostate cancer and history of depression.  **Seizures**: None  **Protocol on file**: N/A |
| Current Prescription Medications:   |  |  |  |  | | --- | --- | --- | --- | | **Medication:** | **Dosage:** | **Time:** | **Reason:** | | **ASA (Aspirin) EC** | **81mg** | **Daily** |  | | **Vit D.** | **1000 units/1 tab** |  |  | | **Risperidone** | **0.5mg** | **Bedtime** |  | | **Trazodone HCL** | **100mg** | **Bedtime** |  | | **Acetaminophen** | **650mg** | **Every 4-6 hours as needed** |  | | **Clindamycin HCL** | **600mg** | **1 hour prior to dental appts.** |  | |  |  |  |  | |  |  |  |  | |
| **Allergies:** Penicillin  **Special Diet:** Low sodium; no added salt. |
| **CONSUMER CONTACTS / LICENSE HOLDERS** |
| |  |  | | --- | --- | | **Emergency Contact Person(s): Karen Offerdahl**  Address: 1122 Elm Street #503  Honolulu, Hawaii  Phone Number: 808-697-6415 (work)  Cell: 808-781-5933  Fax: 808-697-6416  E-Mail: kofferdahl@financialguide.com | **Family Choice of Alternate Emergency Contact: Susan Offerdahl**  Address: PO Box 68160 Dubai, UAE 00000  Phone Number: 011-97-150-465-4400 (Skype name: susanofferdahl)  Cell: NA  Fax: NA  E-Mail: [susanofferdahl@gmail.com](mailto:susanofferdahl@gmail.com) | | **Family Choice of Alternate Emergency Contact: Jim Ostlund (friend)**  Address: 1576 Royal Hills Drive,  Arden Hills, MN 55112  Phone: 651-523-7870  Fax:651-259-6805  E-mail: jim.ostlund@sunrisebanks.com | **Legal Representative: Karen Offerdahl**  Address: 1122 Elm Street #503  Honolulu, Hawaii  Phone Number: 808-697-6415 (work)  Cell: 808-781-5933  Fax: 808-697-6416  E-Mail: kofferdahl@financialguide.com | | **Legal Representative: Susan Offerdahl**  Address: PO Box 68160  Dubai, UAE 00000  Phone Number: +9599 7249 4540.  Skype name: susanofferdahl  Cell: NA  Fax: NA  E-Mail: [susanofferdahl@gmail.com](mailto:susanofferdahl@gmail.com) | **Parents: NA**  Address:  Phone Number:  Cell:  Fax:  E-Mail: | | **Residential Provider: High Quality Services**  Address: 8617 Edinbrook Crossing  Brooklyn Park, MN 55443  Phone Number: 763-657-0612  Cell: 612-418-6343  Fax: 612-977-3960  E-Mail: Elizabeth.Noterman@High Qualityservices.org  Contact Person: Elizabeth Noterman | **County Case Manager: Chris Eck**  Address: PO Box X  Bagley, MN 56621  Phone Number: 218-694-6164  Cell: NA  Fax: 218-694-6163  E-Mail: chris.eck@co.clearwater.mn.us | | **County Financial Worker: Hennepin County Team 254 (Laura Haulbrick)**  Address: NA  Phone Number: 612-543-0170  Cell: NA  Fax: 612-632-8655  E-Mail: Laura.Haubrick@hennepin.us | **Health Care Power of Attorney: Karen Offerdahl**  Address: 1122 Elm Street #503  Honolulu, Hawaii  Phone Number: 808-697-6415 (work)  Cell: 808-781-5933  Fax: 808-697-6416  E-Mail: kofferdahl@financialguide.com | | **Speech Therapist: Courage Center (Allison Isenberg, Abigail Carhill, Julie Carey)**  Address: 3915 Golden Valley Road  Minneapolis, MN 55422  Phone: 763-588-0811  Fax: 763-230-1905  E-mail: NA | **Physician: Dr. Gary Knudsen**  Address: Health East Midway Clinic,  1390 University Avenue W.  St. Paul, MN 55104  Phone Number: 651-232-4886 or 651-232-4800  Cell: NA  Fax: 651-232-5024 | | **Hospital of Preference: St. Joseph’s Hospital**  Address: 45 West 10th Street  St. Paul, MN 55102  Phone Number: 651-232-3000  Cell: NA  Fax: 651-232-3539  E-Mail: NA | **Dentist: Dr. Walter Hunt**  Address: Personal Care Dentistry  2233 North Hamline Ave, Suite 320  Roseville, MN 55113  Phone Number: 651-964-3711  Cell: NA  Fax: 651-636-3775  E-Mail: NA | | **Counseling: Courage Center (Leslie Meyer)**  Address: 3915 Golden Valley Road  Minneapolis, MN 55422  Phone Number: 763-588-0811  Fax: 763-230-1905  E-Mail: NA | **Care Coordinator: Courage Center (Susan Sandahl)**  Address: 3915 Golden Valley Road  Minneapolis, MN 55422  Phone Number: 763-588-0811  Fax: 763-230-1905  E-Mail:sue.sandahl@couragecenter.org | | **Cardiologist: Dr. Li**  Address: St. Joseph’s Hospital  45th West 10th Street  St. Paul, MN 55102  Phone Number: 651-232-3000  Fax: 651-232-3539  E-Mail: NA | **Oncologist: Dr. Cheema**  Address: 1575 Beam Avenue  Maplewood, MN 55109  Phone Number: 651-232-7970  Fax: Not provided  E-Mail: NA | | **Transportation Company: Metro Mobility**  Address: 390 Robert St N  St Paul, MN 55101  Number: 651-602-1100 extension #1 (Scheduling)  Fax: NA  E-Mail: NA | **Transportation Company: Medi-Van**  Address: NA  Phone Number: 218-847-1729  Fax: 877-417-4380  E-Mail: NA | |
| **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**  Cell: 612-723-5859  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** |
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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. |
| 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 Mark that he have a stable living situation and part time employment. It is important for Mark to be able to attend all his scheduled activities.  Status of social relationships and natural supports: Mark is close to his family and his friend, Jim. Mark will be moving into a home with younger guys which he is excited about.  Recent inclusion and participation in the community: Mark participates in a lot of activities in the community. He goes to classes at Methodist Hospital, St. John’s Hospital and also participates in classes thru MnCan and RAADP. Mark also works out at the YMCA.  New or ongoing opportunities for the development and exercise of functional and age-appropriate skills, decision making and choice, personal advocacy, and communication: Mark has been participating in Inspire Art of Expression.  Description of relevant behavioral issues: There are no behavioral issues.  Description of relevant health issues: Mark was diagnosed with prostate cancer.  Other information as requested by the support team, please indicate: Mark’s team gets updates every week. |
| 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: High Quality is not contracted to provide psychotropic medication monitoring. |

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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:  Mark is on a low-sodium, no added salt diet. Staff will support Mark’s dietary needs while shopping in the community. Mark was diagnosed with prostate cancer in July 2014. Staff will schedule Mark’s transportation to ensure that Mark attends all his scheduled activities and medical appointments. |
| The scope of the services to be provided to support the person’s daily needs and activities include:  Mark meets with his ILS staff every week for a 2 hour shift. Mark works with his ILS staff on healthy eating and getting out in the community. Mark will run errands with ILS staff to pick up personal need items. Mark’s ILS staff will assist with tracking his scheduled pick up times with Metro Mobility and prompting notify his staff when a ride needs to be changed or cancelled. |
| 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**:  Mark prefers someone who can get his errands or tasks completed in a timely manner. Mark requires a consistent staff who can be flexible to his needs. |
| 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?  Mark’s team will be notified of any incident reports or vulnerable adult reports. Mark’s team will also receive weekly updates and notifications of any problems with Metro Mobility.  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:  **Karen Offerdahl**  Address: 1122 Elm Street #503  Honolulu, Hawaii  Phone Number: 808-697-6415 (work)  Cell: 808-781-5933  Fax: 808-697-6416  E-Mail: [kofferdahl@financialguide.com](mailto:kofferdahl@financialguide.com)  **Susan Offerdahl**  Address: PO Box 68160 Dubai, UAE 00000  Phone Number: 011-97-150-465-4400 (Skype name: susanofferdahl)  Cell: NA  Fax: NA  E-Mail: [susanofferdahl@gmail.com](mailto:susanofferdahl@gmail.com)  **Chris Eck**  Address: PO Box X  Bagley, MN 56621  Phone Number: 218-694-6164  Cell: NA  Fax: 218-694-6163  E-Mail: chris.eck@co.clearwater.mn.us  **Jim Ostlund**  Address: 1576 Royal Hills Drive,  Arden Hills, MN 55112  Phone: 651-523-7870  Fax:651-259-6805  E-mail: jim.ostlund@sunrisebanks.com |
| 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: Staff need to know Mark sometimes gets frustrated talking on the phone if he is having a difficult time discussing what is on his mind. Staff will talk to Mark in a clear and concise manner. Staff may need to speak slowly to Mark over the phone. |
| 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: 7/28/15  Meeting Attendance: Jim, Mark, Jessica, Arianna, Karen and Chris via phone.  Description of Consumer’s participation in conference process: Mark was completing job applications however remained active in the meeting.  Review of Guardianship or Conservatorship Status: It is appropriate.  Review of Placement and Appropriateness: Mark will be moving out of Edinbrook and moving into a GRH home in the Fall 0f 2015. It is appropriate for him. |
| 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: |