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| COORDINATED SERVICE AND SUPPORT PLAN (CSSP) ADDENDUM – BASIC SUPPORT SERVICES |
| Name of person served:  Date of development:        For the annual period from:        to        Name and title of person completing the *CSSP Addendum*: Legal representative: Case manager:  |
| Dates of development:* Within 15 calendar days of service initiation, the license holder must complete the preliminary *CSSP Addendum* based upon the *CSSP.*
* Within 60 calendar days of service initiation, the license holder must review and revise as needed the preliminary CSSP Addendum to document the services as directed below.
* As requested, the support team reviews the *CSSP Addendum.*
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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.  |
| **Services** to be provided by this company including positive support strategies:  |
| Describe **how** the services will be provided:   |
| Describe **when** the services will be provided (may include frequency and length as applicable):  |
| Describe **who** will be providing this service:  |
| Provide the **name, title, and contact information** for the person(s) responsible for overseeing the delivery and coordination of services:Name: Title: Address and phone number: Email:  |
| Are there services that must 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?  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:  |
| Does the person require a **restriction of their rights** **as listed in 245D.04, subdivision 3** 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 [ ]  NA – not applicable for this serviceIf 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.  |
| 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”: If health service responsibilities are assigned to this license holder, , the case manager and legal representative will be promptly notified of any changes in the person’s physical and mental health needs affecting the health service needs, unless otherwise specified here: . |
| 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  |
| 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.
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| Psychotropic medication monitoring and use  |
| Is this person prescribed psychotropic medication? [ ]  Yes [ ]  NoHas the license holder been assigned responsibility for the medication administration of the psychotropic medication? [ ]  Yes [ ]  NoIf yes, the following information will be maintained by the company:Describe the target symptoms the psychotropic medication is to alleviate:  1. Does the prescriber require documentation to monitor and measure changes in the target symptoms that are to be alleviated by the psychotropic medications?

 [ ]  Yes [ ]  NoIf yes, please indicate the documentation methods to be used to collect and report on medication and symptom-related data according to the prescriber’s instructions:   |
| Permitted actions and procedures |
| On a continuous basis, does the person require the **use of permitted actions and procedures** thatincludes physical contact or instructional techniques:1. To calm or comfort a person by holding that person with no resistance from the person.

[ ]  Yes [ ]  No If yes, explain how it will be used:1. To protect a person known to be at risk of injury due to frequent falls as a result of a medical condition.

[ ]  Yes [ ]  No If yes, explain how it will be used: 1. To facilitate a person’s completion of a task or response when the person does not resist or it is minimal:

[ ]  Yes [ ]  No If yes, explain how it will be used:1. To block or redirect a person’s limbs or body without holding or limiting their movement to interrupt a behavior that may result in injury to self or others with less than 60 seconds of physical contact by staff.

[ ]  Yes [ ]  No If yes, explain how it will be used:1. To redirect a person’s behavior when the behavior does not pose a serious threat to self or others and the behavior is effectively redirected with less than 60 seconds of physical contact by staff.

[ ]  Yes [ ]  No If yes, explain how it will be used:1. To allow a licensed health care professional to safely conduct a medical examination or to provide medical treatment.

[ ]  Yes [ ]  No If yes, explain how it will be used:1. Assist in the safe evacuation or redirection of a person in an emergency and they are at imminent risk of harm.

[ ]  Yes [ ]  No If yes, explain how it will be used:1. Is a restraint needed as an intervention procedure to position this person due to physical disabilities?

[ ]  Yes [ ]  No If yes, explain how it will be used:1. Is positive verbal correction specifically focused on the behavior being addressed?

[ ]  Yes [ ]  No If yes, explain how it will be used: 1. Is temporary withholding or removal of objects being used to hurt self or others being addressed?

[ ]  Yes [ ]  No If yes, explain how it will be used: 1. Are adaptive aids or equipment, orthotic devices, or other medical equipment ordered by a licensed health professional to treat a diagnosed medical condition being used?

[ ]  Yes [ ]  No If yes, explain how it will be used:  |
| **Staff information** |
| Are any **additional requirements** requested for staff to have or obtain in order to meet the needs of the person? [ ]  Yes [ ]  NoIf 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 |
| **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*:

[ ]  Quarterly [ ]  Semi-annually [ ]  Annually [ ]  As requested1. Frequency of service plan review meetings:

[ ]  Quarterly [ ]  Semi-annually [ ]  Annually [ ]  As requested1. Frequency of receipt of *Psychotropic Medication Monitoring Data Reports*, this will be done quarterly unless otherwise requested:

[ ]  Quarterly [ ]  Semi-annually [ ]  Annually [ ]  NA1. 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 [ ]  Semi-annually [ ]  Annually [ ]  NA1. 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:

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

[ ]  Quarterly [ ]  Semi-annually [ ]  Annually [ ]  NA  |
| **Meeting minutes:**  |

**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: |
| Licensed provider contact: | Date: |
| Other support team member (name and title):  | Date: |
| Other support team member (name and title):  | Date: |