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| **SUPPORT PLAN ADDENDUM – INTENSIVE SERVICES** |
| Name of person served: Date of development: For the annual period from: To: Name and title of person completing the *Support Plan Addendum*: Legal representative: Case manager:  |
| 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 will be assessed by the person and/or legal representative, case manager, support team or expanded support team members, and other people as identified by the person and/or legal representative.Dates of development: * Within 15 days of service initiation, the license holder must complete the preliminary *Support Plan Addendum.*
* Before providing 45 days of service or within 60 calendar days of service initiation.
* Annually, the support team reviews the *Support Plan Addendum*.
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| **Services and Supports** |
| The **scope of the services** to be provided to support the person’s daily needs and activities include:  |
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| The person’s **desired outcomes** and the methods or actions that will be used to support the person and to accomplish the service outcomes (Service Outcomes and Supports): Outcome #1:  Outcome #2:  Outcome #3:  |
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| A discussion of how **technology** may be used to meet the person’s desired outcomes has occurred: [ ]  Yes [ ]  NoProvide a summary that describes decisions made regarding the use of technology and a description of any further research that needs to be completed before a decision regarding the use of technology can be made:  |
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| Describe the **general and health-related supports** necessary to support this person based upon each area of the *Self-Management Assessment (SMA)* and the requirements of person-centered planning and service delivery:  |
| The person’s **preferences** for how services and supports are provided including positive support strategies and how the provider will support the person to **have control of their schedule**:  |
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| Is the current service setting the **most integrated setting available and appropriate** for the person? [ ]  Yes [ ]  NoIf no, please describe what action will be taken to address this:  |
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| What are the opportunities to develop and maintain **essential and life-enriching skills, abilities, strengths, interests, and preferences**?   |
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| What are the opportunities **for community access, participation, and inclusion** in preferred community activities?  |
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| What are the opportunities to **develop and strengthen personal relationships** with other persons of the person’s choice in the community?   |
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| What are the opportunities to seek **competitive employment** and work at competitively paying jobs in the community?   |
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| How will services be **coordinated across other 245D licensed providers and members of the 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:  |
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| **The person currently receives services in** (check as applicable): [ ]  Residential services in a community setting controlled by a provider [ ]  Day services [ ]  NeitherProvide a **summary of the discussion** **of options for transitioning the person out of a community setting controlled by a provider** and into a setting not controlled by a provider (residential services). Include a **statement about any decision made regarding transitioning out of a provider-controlled setting**: Provide a **summary of the discussion** **of options for transitioning from day services to an employment service.**  Include a **statement about any decision made regarding transitioning to an employment service**: Click or tap here to enter text.Describe any further research or education that must be completed before a decision regarding this transition can be made:  |
| Does the person require the **presence of staff** at the service site while services are being provided?  [ ]  Yes [ ]  NoIf 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:  |
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| 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 [ ]  NoIf yes, please indicate what right(s) will be restricted: If rights are being restricted the Rights Restrictions form must be completed. |
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| Does this person use **dangerous items or equipment**?  [ ]  Yes [ ]  No**If yes, address any concerns or limitations**:  |
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| 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 [ ]  NoIf yes, the company will not allow the use of manual restraint to be used for the person. |
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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”. 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: 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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| If the license holder is assigned responsibility for medication set up, assistance, or medication administration, the license holder will provide that support according to procedures listed here as applicable:[ ]  Medication set up: [ ]  Medication assistance: [ ]  Medication administration:  |
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| **Psychotropic Medication Monitoring and Use** |
| Does the license holder administer the person’s psychotropic medication? [ ]  Yes [ ]  NoIf yes, document the following information:1. 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 [ ]  No
2. If 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:

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| **Permitted Actions** |
| 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:  |
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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:  |
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| 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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| For facility-based day services only – please indicate the staff ratio required for this person. Additional information on how this ratio was determined is maintained in the person’s service recipient record: [ ]  1:4 [ ]  1:6 [ ]  1:8 [ ]  Other (please specify): [ ]  NA |
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| **Frequency Assessments** |
| 1. Frequency of *Progress Reports and Recommendations*, minimum of annually:

 [ ]  Quarterly [ ]  Semi-annually [ ]  Annually1. Frequency of service plan review meetings, minimum of annually:

 [ ]  Quarterly [ ]  Semi-annually [ ]  Annually1. Request to receive the *Progress Report and Recommendation*:

 [ ]  At the support team meeting [ ]  At least five working days in advance of the support team meeting1. Frequency of receipt of *Psychotropic Medication Monitoring Data Reports*, this will be done quarterly unless otherwise requested:

 [ ]  Quarterly [ ]  Other (specify): [ ]  NA |

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| **Meeting Minutes** |
| Date of Meeting: Click or tap to enter a date.Meeting Minutes: Click or tap here to enter text. |

**SIGNATURE PAGE**

**By signing below, I am indicating the completion and approval of *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:** | Date: |