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| **SELF-MANAGEMENT ASSESSMENT** | | |
| Name: Christopher Green    Date of *Self-Management Assessment* development: 10/28/2015 For the annual period from: 10/28/15 to 10/27/2016    Name and title of person completing the review: Dhimbil Ali, Program Manager | | |
| Within the scope of services to this person, the license holder must assess, at a minimum, the areas included on this document. Additional information on self-management may be included per request of the person served and/or legal representative and case manager. The *Self-Management Assessment* will be completed by the company’s designated staff person and will be done in consultation with the person and members of the support team.  The license holder will complete this assessment before the 45-day planning meeting and review it at the meeting. Within 20 working days of the 45-day meeting, dated signatures will be obtained from the person and/or legal representative and case manager to document the completion and approval of the *Self-Management Assessment.* At a minimum of annually, or within 30 days of a written request from the person and/or legal representative or case manager. This *Self-Management Assessment* will be reviewed by the support team or expanded support team as part of a service plan review and dated signatures obtained.  Assessments must be based on the person’s status within the last 12 months at the time of service initiation. Assessments based on older information must be documented and justified.  The **general and health-specific supports and outcomes necessary or desired to support the person** based upon this assessment and the requirements of person centered planning and service delivery will be documented in the *CSSP Addendum.* | | |
| **Health and medical needs to maintain or improve physical, mental, and emotional well-being** | | |
| **Assessment area** | **Is the person able to self-manage in this area?** | **Assessment – include information about the person that is descriptive of their overall strengths, functional skills and abilities, and behaviors or symptoms** |
| Allergies (state specific allergies): | Yes  No  NA – there are no allergies | Christopher has environmental allergies and Sulfa. Staff will verbally prompt Christopher to leave an area that causes an allergic reactions. |
| Seizures (state specific seizure types): | Yes  No  NA – no seizures |  |
| Choking | Yes  No | Christopher utilizes staff support to cut food up to avoid choking. Staff verbally prompt Christopher to slow down and to take smaller bites. |
| Special dietary needs (state specific need): | Yes  No  NA – there are no special dietary needs | Christopher cannot consume 100% grape juice. Staff will verbally prompt Christopher to avoid this product. |
| Chronic medical conditions (state condition): | Yes  No  NA – there are no chronic medical conditions |  |
| Self-administration of medication or treatment orders | Yes  No | Christopher’s guardian and school nurse will administer medications. |
| Preventative screening | Yes  No | Christopher’s guardian schedules all preventative screenings. |
| Medical and dental appointments | Yes  No | Christopher’s guardian schedules all medical and dental appointments. Christopher may need verbal prompts to comply with doctors’ orders. |
| Other health and medical needs (state specific need): | Yes  No  NA | Christopher may not accurately report injury or illness or may not report to the appropriate person. Christopher has a high tolerance for pain and may not accurately repot to the severity of his injury or illness. Staff will observe Christopher for injury or illness. |
| Other health and medical needs (state specific need): | Yes  No  NA |  |
| Other health and medical needs (state specific need): | Yes  No  NA |  |
| **Personal safety to avoid injury or accident in the service setting** | | |
| **Assessment area** | **Is the person able to self-manage in this area?** | **Assessment – include information about the person that is descriptive of their overall strengths, functional skills and abilities, and behaviors or symptoms** |
| Risk of falling (include the specific risk): | Yes  No  NA – not at risk for falling |  |
| Mobility issues (include the specific issue): | Yes  No  NA – there are no mobility issues | Christopher is ambulatory. |
| Regulating water temperature | Yes  No |  |
| Community survival skills | Yes  No | Christopher lacks understanding of pedestrian safety skills. Staff will verbally prompt Christopher to maintain personal safety. |
| Water safety skills | Yes  No | Christopher may not be to demonstrate water safety skills.Staff will only bring Christopher to a body of water where a life guard is on duty. Staff will encourage him to stay in the shallow end. |
| Sensory disabilities | Yes  No | Christopher has prescription corrective lenses. Christopher has a history of choosing not to wear his glasses and has broken them out of anger or frustration. Staff will verbally remind him the importance of wearing his glasses. Staff will report to guardian if he chooses not to wear his glasses or intentionally breaks them. |
| Other personal safety needs (state specific need): | Yes  No  NA | Christopher’s diagnosis of Autism makes him sensitive to certain environments. Christopher has a history of shutting down in environments that have lots of stimuli such as large crowds. Christopher displays touch sensory by playing with textured items, picking, or peeling at all types of items. Staff will ask Christopher if he is comfortable with the sensory environment and adjust accordingly by leaving the area or finding a sensory item that he enjoys. |
| Other personal safety needs (state specific need): | Yes  No  NA | Christopher would not be able to correctly respond to an emergency situation independently, he may become overwhelmed and shut down. Staff will provide Christopher verbal prompts in an emergency. If he was in immediate danger staff would physically remove him from harm’s way. |
| Other personal safety needs (state specific need): | Yes  No  NA |  |
| **Symptoms or behavior that may otherwise result in an incident as defined in section 245D.02, subd. 11 clauses (4) to (7) or suspension or termination of services by the license holder, or other symptoms or behaviors that may jeopardize the health and safety of the person or others.** | | |
| **Assessment area** | **Is the person able to self-manage in this area?** | **Assessment – include information about the person that is descriptive of their overall strengths, functional skills and abilities, and behaviors or symptoms** |
| Self-injurious behaviors (state behavior): | Yes  No  NA | Christopher has a history of tripping and falling as a joke and throwing his body into walls when upset. Staff will redirect any inappropriate behaviors and review with Christopher alternative behavior. |
| Physical aggression/conduct (state behavior): | Yes  No  NA |  |
| Verbal/emotional aggression (state behavior): | Yes  No  NA |  |
| Property destruction (state behavior): | Yes  No  NA | Christopher has a history of breaking his eye glasses when upset. |
| Suicidal ideations, thoughts, or attempts | Yes  No  NA |  |
| Criminal or unlawful behavior | Yes  No  NA |  |
| Mental or emotional health symptoms and crises (state diagnosis): | Yes  No  NA | Christopher has a history of having “meltdowns” at times of transition. Christopher will if overwhelmed refuse to talk or move. Christopher may throw items or break items like his glasses. He also may throw his body into wall’s. |
| Unauthorized or unexplained absence from a program | Yes  No  NA |  |
| An act or situation involving a person that requires the program to call 911, law enforcement or fire department | Yes  No  NA |  |
| Other symptom or behavior (be specific): | Yes  No  NA |  |

**SIGNATURE PAGE**

**By signing below, I am indicating the completion and approval of the *Self-Management Assessment*.**

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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: |

**Please note:**

Within 20 working days of the 45-day planning meeting (and within 10 working days of the service plan review meeting), the assessment and this addendum must be submitted to and dated signatures obtained dated by the person served and/or legal representative and case manager to document completion and approval. If within 10 working days of this submission, the person served and/or legal representative or case manager has not signed and returned to the license holder the assessment and *Coordinated Service and Support Plan Addendum* or has not proposed written modification to its submission, the submission is deemed approved and in effect. It will remain in effect until the next annual month or until the person served and/or legal representative or case manager submits a written request to revise them.