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| **SELF-MANAGEMENT ASSESSMENT** | | |
| Name: Derek Cody    Date of *Self-Management Assessment* development: April 20th, 2015 For the annual period from: May 27, 2015 to May 26, 2016    Name and title of person completing the review: Jessica Reno, Program Director | | |
| 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 and will assess and review it at the 45-day 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, this *Self-Management Assessment* will be reviewed and dated signatures obtained.  The general and health-specific supports necessary 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 |  |
| Seizures (state specific seizure types): | Yes  No  NA – no seizures |  |
| Choking | Yes  No |  |
| Special dietary needs (state specific need): | Yes  No  NA – there are no special dietary needs |  |
| Chronic medical conditions (state condition): | Yes  No  NA – there are no chronic medical conditions |  |
| Self-administration of medication or treatment orders | Yes  No | Derek does not administer medications independently. High Quality Services is not responsible for medication administration during ILS shifts. |
| Preventative screening | Yes  No | Derek may over report an illness to get out of school or may not seek assistance if requiring medical treatment if needed. |
| Medical and dental appointments | Yes  No | Derek’s Legal Guardian is responsible for all of his medical needs. High Quality staff will visually observe Derek for any injury or illness and report them to Derek’s Legal Guardian. |
| Other health and medical needs (state specific need): | Yes  No  NA |  |
| 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 |  |
| Regulating water temperature | Yes  No |  |
| Community survival skills | Yes  No | Derek knows what behaviors are socially acceptable, but may not always behave in those ways. |
| Water safety skills | Yes  No | Derek can swim and demonstrates good water safety skills. Derek and ILS Staff will only go to bodies of water with a lifeguard present. |
| Sensory disabilities | Yes  No  NA – no sensory disabilities |  |
| Other personal safety needs (state specific need):  **Associating consequences with actions.** | Yes  No  NA | Derek may not associate consequences with his actions at times. |
| Other personal safety needs (state specific need): | Yes  No  NA |  |
| 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 |  |
| Physical aggression/conduct (state behavior): **Defend self against abuse/ behaviors which may provoke abuse** | Yes  No  NA | If Derek is teased or picked on he may become physically aggressive. |
| Verbal/emotional aggression (state behavior): **Behaviors which may provoke abuse** | Yes  No  NA | If Derek is teased or picked on he may become physically aggressive. |
| Property destruction (state behavior): | Yes  No  NA |  |
| Suicidal ideations, thoughts, or attempts | Yes  No  NA |  |
| Criminal or unlawful behavior | Yes  No  NA |  |
| Mental health symptoms and crises (state diagnosis): **Autism Spectrum Disorder, Learning Disability, ADHD** | Yes  No  NA | Derek is diagnosed with Autism Spectrum Disorder, Learning Disability, and Attention Deficit Hyperactivity Disorder. |
| Emotional health symptoms (state diagnosis): | Yes  No  NA |  |
| Unauthorized or unexplained absence from a program | Yes  No  NA | Derek has a history of leaving home without notifying his guardian or staff. |
| 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: |