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**SELF-MANAGEMENT ASSESSMENT**

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| --- | --- | --- |
| **Name:**    **Date of *Self-Management Assessment* development: For the annual period from:**    **Name and title of person completing the review:** Fahad Abdalla, Program Administrator | | |
| 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 |  |
| Seizures (state specific seizure types): | Yes  No  NA – no seizures |  |
| Choking | Yes  No  NA – there are no choking hazards |  |
| Special dietary needs (state specific need): | Yes  No  NA – there are no special dietary needs | He is mindful of his dietary needs to be able to continue to promote his weight loss. James can communicate his preferences to his supports relating to what he wants/needs for meals. Homemaker is able to assist with meal prep if requested by James. |
| Chronic medical conditions (state condition): | Yes  No  NA – there are no chronic medical conditions | Acute but ill defined CVA, Unspecified Tachacardia, Unsp. Essential Hypertension, Hemiplegia, Hemiparesis, Hx Seizures. |
| Self-administration of medication or treatment orders | Yes  No | James has several medications so it can be difficult for him to track all of them and take them at their prescribed time. James does understand the importance of his medications, knows his medication times, and does not have an issue with missing doses. James has been successful with using a pill box to make sure his meds are organized and easy for him to identify when to take which medications. |
| Preventative screening | Yes  No |  |
| Medical and dental appointments | Yes  No |  |
| 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 |  |
| Water safety skills | Yes  No |  |
| Sensory disabilities | Yes  No  NA |  |
| Other personal safety needs (state specific need): | Yes  No  NA |  |
| 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): | Yes  No  NA |  |
| Verbal/emotional aggression (state behavior): | Yes  No  NA |  |
| Property destruction (state behavior): | Yes  No  NA |  |
| 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 | James has a diagnosis of PTSD and experiences some mild depression and anxiety but it is not being treated with medications or therapy at this time. His physician is aware of the diagnosis and monitors James for symptoms. James is able to recognize if he is having any issues and will inform his physician and supports to address. |
| 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 |  |

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**SIGNATURE PAGE**

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

|  |  |
| --- | --- |
| **Person served:** | **Date:** |
| **Legal representative/guardian:** | **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.