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| **SELF-MANAGEMENT ASSESSMENT** | | |
| Name: Alexis Mack    Date of *Self-Management Assessment* development: 12/16/2015 For the annual period from: December 21, 2015 to December 20, 2016    Name and title of person completing the review: Jill Manthei, Program Coordinator | | |
| 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 | Alexis’ mom sets up her pills and provides reminders for her to take them. |
| Preventative screening | Yes  No | Alexis may not seek assistance for her own medical needs. Jill schedules Alexis’ appointments. |
| Medical and dental appointments | Yes  No | Alexis may not seek assistance for her own medical needs. Jill schedules Alexis’ appointments. |
| Other health and medical needs (state specific need): | Yes  No  NA | ILS staff may be asked by Alexis’ mom to be transported to medical appointments. Alexis’ mom would meet them at the appointment and assist Alexis in the appointment, then staff would transport Alexis at the end of appointment. |
| 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 | Alexis has taken swimming lessons and is at level #4. Alexis requires adult supervision when swimming. |
| Sensory disabilities | Yes  No |  |
| 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 | Alexis may display self-injurious behaviors. When angry, she may pound or hit walls and slam doors. Alexis has a history of repeatedly picking at scabs and causing them not to heal properly or promptly. She will also pick at her fingers and bite her lips. |
| Physical aggression/conduct (state behavior): | Yes  No  NA | Alexis may be physically aggressive when she is upset. |
| Verbal/emotional aggression (state behavior): | Yes  No  NA | Alexis may be verbally aggressive towards her sisters. |
| 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): | Yes  No  NA |  |
| Emotional health symptoms (state diagnosis): | Yes  No  NA |  |
| 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 | Alexis is unable to respond to an emergency independently. Alexis displays some knowledge of what to do in a fire or weather emergency. Alexis is aware of what to do if the fire alarms go off at school. She may recognize that there is an emergency and know what to do, but not take the action to be safe. |
| 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: |