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**SELF-MANAGEMENT ASSESSMENT**

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| --- | --- | --- |
| **Name: Danielle Otto**    **Date of *Self-Management Assessment* development: 02/25/2021 For the annual period from: 04/01/2020 to 03/31/2021**    **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 | Dee will utilize her HDM to maintain her health and assure she has at least one healthy meal a day.  Optage will provide Dee with a nutritious gluten free meal |
| Chronic medical conditions (state condition): | Yes  No  NA – there are no chronic medical conditions | Bipolar, Affective (F31.9), Lymes Disease (A69.20 |
| Self-administration of medication or treatment orders | Yes  No | Dee is able to administer her own medications and feels safe doing so. |
| 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 | Dee utilized a walker. |
| 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 | Dee stated she has been isolating herself more, but she is working on this. She stated she is not feeling well physically or mentally and this leads to her isolation.  Bipolar, Affective (F31.9), Lymes Disease (A69.20 |
| 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.