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| **Intensive Support Self-Management Assessment** |
| REQUIREMENTS FOR USE OF THIS SAMPLE DOCUMENT: 245D license holders are responsible for modifying this sample for use in their program. At a minimum, you must fill in the blanks on this form. You may modify the format and content to meet standards used by your program. This sample meets compliance with current licensing requirements as of January 1, 2014. Providers remain responsible for reading, understanding and ensuring that this document conforms to current licensing requirements. DELETE THIS HIGHLIGHTED SECTION TO BEGIN MODIFYING THIS FORM. |
| **Person Name:** |
| **Program Name:**  |
| **Date of Service Initiation:**  |
| **Date of Assessment (within 45 days of service initiation):**  |
| The following assessment must be based on the person’s status within the last 12 months at the time of service initiation. An assessment based on older information must be documented and justified. Assessments must be conducted annually at a minimum or within 30 days of a request from the person or the person’s legal representative or case manager. The results must be reviewed by the support team or expanded support team as part of a service plan review. The information produced as a result of this assessment must describe the person’s overall strengths, functional skills and abilities, and behaviors or symptoms. The assessment information provides the basis for identifying and developing supports to be provided to the person and methods to be implemented to support the accomplishment of outcomes related to acquiring, retaining or improving skills. Use the program’s Person-Centered Planning Checklist to assist in the assessment process and when developing supports and outcomes. |
| **Health and Medical Needs**Assessment of the person’s ability to self-manage health and medical needs to maintain or improve physical, mental, and emotional well-being |
| **Assessment Area** | **Does the person need or want supports in this area:** | **Overall strengths, functional skills, and abilities in this area:** | **Behaviors and symptoms affecting the person’s ability to self-manage needs in this area:** | **Does the person need or want to set an outcome related to acquiring, retaining, or improving skills in this area?** |
| **Allergies** | [ ]  Yes [ ]  No [ ]  NA  |  |  | [ ]  Yes [ ]  No [ ]  NA  |
| **Seizures** | [ ]  Yes [ ]  No [ ]  NA  |  |  | [ ]  Yes [ ]  No [ ]  NA  |
| **Choking** | [ ]  Yes [ ]  No [ ]  NA  |  |  | [ ]  Yes [ ]  No [ ]  NA  |
| **Special Dietary Needs** | [ ]  Yes [ ]  No [ ]  NA  |  |  | [ ]  Yes [ ]  No [ ]  NA  |
| **Chronic Medical Conditions** | [ ]  Yes [ ]  No [ ]  NA  |  |  | [ ]  Yes [ ]  No [ ]  NA  |
| **Self-Administration of Medication or Treatment Orders** | [ ]  Yes [ ]  No [ ]  NA  |  |  | [ ]  Yes [ ]  No [ ]  NA  |
| **Preventative Screening** | [ ]  Yes [ ]  No [ ]  NA  |  |  | [ ]  Yes [ ]  No [ ]  NA  |
| **Medical and Dental Appointments** | [ ]  Yes [ ]  No [ ]  NA  |  |  | [ ]  Yes [ ]  No [ ]  NA  |
| **Other Health and Medical Needs:** | [ ]  Yes [ ]  No [ ]  NA  |  |  | [ ]  Yes [ ]  No [ ]  NA  |
| **Other Health and Medical Needs:** | [ ]  Yes [ ]  No [ ]  NA  |  |  | [ ]  Yes [ ]  No [ ]  NA  |
| **Personal Safety**Assessment of the person’s ability to self-manage personal safety to avoid injury or accident in the service setting |
| **Assessment Area** | **Does the person need or want supports in this area:** | **Overall strengths, functional skills, and abilities in this area:** | **Behaviors and symptoms affecting the person’s ability to self-manage needs in this area:** | **Does the person need or want to set an outcome related to acquiring, retaining, or improving skills in this area?** |
| **Risk of Falling** | [ ]  Yes [ ]  No [ ]  NA |  |  | [ ]  Yes [ ]  No [ ]  NA  |
| **Mobility** | [ ]  Yes [ ]  No [ ]  NA |  |  | [ ]  Yes [ ]  No [ ]  NA  |
| **Regulating Water Temperature** | [ ]  Yes [ ]  No [ ]  NA |  |  | [ ]  Yes [ ]  No [ ]  NA  |
| **Community Survival Skills** | [ ]  Yes [ ]  No [ ]  NA |  |  | [ ]  Yes [ ]  No [ ]  NA  |
| **Water Safety Skills** | [ ]  Yes [ ]  No [ ]  NA |  |  | [ ]  Yes [ ]  No [ ]  NA  |
| **Sensory Disabilities** | [ ]  Yes [ ]  No [ ]  NA |  |  | [ ]  Yes [ ]  No [ ]  NA  |
| **Other Personal Safety Needs:** | [ ]  Yes [ ]  No [ ]  NA |  |  | [ ]  Yes [ ]  No [ ]  NA |
| **Other Personal Safety Needs:** | [ ]  Yes [ ]  No [ ]  NA |  |  | [ ]  Yes [ ]  No [ ]  NA |
| **Self-Management of Symptoms or Behaviors** |
| **Assessment Area** | **Does the person need or want supports in this area:** | **Overall strengths, functional skills, and abilities in this area:** | **Behaviors and symptoms affecting the person’s ability to self-manage needs in this area:** | **Does the person need or want to set an outcome related to acquiring, retaining, or improving skills in this area?** |
| **Ability to self-manage symptoms or behavior that may otherwise result in an incident** | [ ]  Yes [ ]  No [ ]  NA |  |  | [ ]  Yes [ ]  No [ ]  NA  |
| **Ability to self-manage symptoms or behavior that may otherwise result in suspension or termination of services** | [ ]  Yes [ ]  No [ ]  NA |  |  | [ ]  Yes [ ]  No [ ]  NA  |
| **Other symptoms or behaviors that may jeopardize the health and safety of the person or others** | [ ]  Yes [ ]  No [ ]  NA |  |  | [ ]  Yes [ ]  No [ ]  NA  |
| **Other Symptoms or Behaviors:** | [ ]  Yes [ ]  No [ ]  NA |  |  | [ ]  Yes [ ]  No [ ]  NA  |
| **Other Symptoms or Behaviors:** | [ ]  Yes [ ]  No [ ]  NA |  |  | [ ]  Yes [ ]  No [ ]  NA  |
| **Assessment and initial service planning meeting participants:** |
| **Name** | **Signature** | **Title** | **Date** |
|  |  | Person Completing Assessment |  |
|  |  | Person |  |
|  |  | Legal Representative |  |
|  |  | Case Manager |  |
|  |  | Program Representative |  |
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| **If the person, the person’s legal representative (if any), or case manager did not participate in this meeting, document when they were notified of the meeting and invited to participate, and why they did not participate:** |
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