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| **Intensive Support Self-Management Assessment** | | | | | | | |
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| **Person Name:** | | | | | | | |
| **Company 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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