Name of Individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Setting(s) of assessment (home, work, recreation, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Health-Related Activities (TASK(S)) being assessed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(i.e.: blood pressure, CPAP, pulse oximetry, compression hose, etc.)

**This assessment is to be completed by a person who knows the individual well, and, when possible, with a second observer present. Assess the individual’s knowledge and skills in each environment where the health care task is performed. Persons conducting this assessment will need to have ALL necessary information regarding the individual’s current physician’s orders for the health care task. In addition, persons completing this assessment must know how to properly complete the task, use and maintain any equipment for performance of the health care task. Complete this form (pages 1-2) in its entirety regardless of answers.** (See *Introduction-Instruction Self-Administration Assessments* for more information)

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ Name, Signature & Title of Second Observer Date

**1. Knows why health care task is ordered.**

**Yes**  Continue to #2 **No**  Unable to Self-Administer With or Without Assistance. Continue to #2

**2. Knows how to use the equipment for the task (i.e., blood pressure cuff, pulse oximeter, etc.).**

**Yes**  Continue to #3 **No**  Unable to Self-Administer With or Without Assistance. Continue to #3

**3. Recognizes if equipment is working correctly.**

**Yes**  Continue to #4 **No**  Unable to Self-Administer With or Without Assistance. Continue to #4

**4.** **Knows who to ask/tell when there is a problem with equipment and will notify that person immediately of any**

**problems (i.e., equipment not working, battery needs changed).**

**Yes**  Continue to #5 **No**  Unable to Self-Administer With or Without Assistance. Continue to #5

**5. Knows what to do with the number/test result (i.e., tell/show someone, write it down, seeks help).**

**Yes**  Continue to #6 **No**  Unable to Self-Administer With or Without Assistance. **NA**  Continue to #6

**6. Knows the right time/day to complete health care task by using a clock, routine, symptom (i.e., first day of work**

**week, before church, before meals, before bedtime, shortness of breath, distress).**

**Yes**  Continue to #7 **No**  If able to self-administer (questions 1-5 are all “Yes”; outcome is “Self-administration with assistance”), the service plan will include need for reminder assistance. Continue to #7

**7. Knows how to clean and maintain equipment.**

**Yes**  Continue to #8 **No**  If able to self-administer (questions 1-5 are all “Yes”, outcome is “Self-Administration with assistance”), the service plan will include need for assistance with cleaning equipment. Continue to #8

**8. Able to get equipment and supplies to/from storage, out of container, assemble equipment.**

**Yes**  If “Yes” to all eight questions, able to Self-Administer Without Assistance **No**  If able to self-

administer (questions 1-5 are all “Yes”; outcome is “Self-Administration with assistance”), the service plan will include need for physical assistance regarding storage, packaging.

**Record Assessment Outcome on page 2**

**Assessment Outcome:**

The individual service plan (ISP) must indicate the outcome of the assessment and how the health care task will be done (assessment outcome plus supports if needed). Based on all answers to questions 1-8, choose one of the outcomes listed below:

Able to “self-administer” without assistance (Questions 1 through 8 are all “Yes”)

Able to “self-administer” with assistance (Questions 1-5 are all “Yes”; any one or all of 6 through 8 are “No”). OAC 5123:2-6-02 specifies the three types of assistance that can be provided by **uncertified** personnel. Indicate below the type or types of assistance that apply. Provide specific instruction in the individual’s ISP.

1. The individual receives assistance with health care task through reminders of when to perform the task.

2. The individual receives assistance with health care task through physical assistance with getting equipment out of storage.

3. Upon request or with consent, and at the **individual’s direction**, receives physical assistance with any or all the following: getting supplies out of container; assembly of equipment.

Unable to perform health care task with or without one of the three types of assistance. (the answer is “No” to any one or all of questions 1-5). Choose one of the following:

The individual is able to perform some steps of health care task and a properly licensed or certified and authorized person completes the other steps of the health care task. (List details in ISP).

A properly licensed or certified and authorized person is required to assist with or perform the health care task.

**Other Considerations:**

Because of demonstrated and documented unsafe behaviors, the individual is unable to safely perform health care tasks with or without assistance. If yes, according to rule (Ohio Administrative Code 5123:2-2-06, Behavior Support Strategies that include Restrictive Measures), this must be addressed as a rights restriction in the ISP. Brief summary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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The individual has oral, topical, inhaled medications or specific health care tasks. Use the specific Self-Administration Assessment for Medication - oral/topical, Oxygen, Inhaled Medications and/or Using a Glucometer to determine level of independence, assistance or supports needed.

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*** *The Self-Administration Assessment must be completed at a minimum of every 3 years, with a review completed annually.*

**Annual Review; the confirmation of no changes**

**First Review**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name, Signature & Title of Person Performing Assessment Date

**Second Review**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name, Signature & Title of Person Performing Assessment Date