SELF-ADMINISTRATION OF MEDICATION ASSESSMENT
Illinois Department of Human Services
Division of Developmental Disabilities

Client Name:_________________________________ SS# _______-_______-_______ Medicaid ID #________________

Provider Name:_________________________________ ID # _________________ DHS Network: ___________________

General Instructions:

1) For all responses to items, place the **letter** of the choices immediately below in the "**HOW**" box to indicate how the answer to the question was obtained.

W) In writing/reading | O) Orally | Sg) By Signaling
Pa) By a physical action | S) By signing | U) Unable to answer

1) For all responses to items, place the **letter** of the choices immediately below in the "**MANNER**" box to indicate how the client demonstrated their capability.

C) Chooses correct performance of activity | P) Performs activity
D) Directs performance of activity by another

If a "NO" answer occurs for program participation or any assessment item or the client refuses to participate in a self-medication program, independent capability and functioning cannot be confirmed. The client and interdisciplinary team should, as appropriate, develop and implement a self-medication training program or a training program in preliminary skills attainment. A detailed DHS self-medication training instrument is available upon request for evaluation of medication training program needs at Bureau of Clinical Services, 319 East Madison, Suite 2A, Springfield, IL, 62701.

The "Self-Administration of Medication Assessment (SAMA) Report Page," (page 3 of this form) is the only page of the SAMA form you need submit to DHS if you are a community provider. SODC and community providers should retain all of this form for your records.

DOMAIN	Program Participation	YES	NO	HOW
Preference	Indicates willingness to participate in a medication self-administration program.			

If answer is **YES:** Proceed to Assessment

If answer is **NO** or client is unable to answer:
1) STOP and complete page 3.
2) Re-assess in one year, or as indicated.

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When program participation preference is "NO;" qualified persons must administer medications.

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CLIENT NAME: ____DATE: ____________________

HOW		MANNER
W) In writing/reading	**S**) By signing	**D**) Directs performance or activity
Pa) By a physical action	**Sg**) By signaling	**C**) Chooses correct performance of activity
O) Orally	**U**) Unable to answer	**P**) Performs activity

SELF-ADMINISTRATION OF MEDICATION ASSESSMENT (SAMA)

When all items below are accomplished (answered "YES"), the individual is independent in self-administration of medications. Tasks must be performed at the individual's medication storage site under visual supervision of a qualified person. Physical adaptations, supports, and/or accommodations should not prevent "YES" ratings on item performance when cognitive capacity is sufficient to support understanding.

ITEM	YES	NO	HOW	MANNER
1. Person identifies rules for safe self-administration of medication: a. Indicates will not share medication with others. b. Indicates will not take someone else's medication.				
2. Person performs the necessary sanitary procedures before administration of medications: a. Wash or clean hands. b. Obtain clean utensils or containers.				
3. Person identifies and/or is able to recognize need to follow any special instructions that may arise connected with particular medications (i.e. Take on empty stomach, take with meals, avoid dairy products, etc.)				
4. Person obtains the correct items for taking medications (i.e. water, applesauce, thicken, etc.)				
5. Person identifies correct time of day to take (administer) each of their particular medications.				
6. Person removes the correct medication from the medication supply for that particular administration time.				
7. Person removes the correct amount of the correct medication from the medication supply for that particular administration time.				
8. Person takes the medication in the prescribed way.				
9. Person returns medication container (supply) to the storage unit.				
10. Person performs the necessary sanitary procedures after administration of medications: a. Disposing or cleaning used utensils or containers. b. Refrigerating necessary items (i.e. applesauce).				
11. Person identifies how to keep track of medications and how to obtain medication refills.				

If all items are answered "**YES**" proceed to page 3 of the SAMA, complete all appropriate sections including the "Certification of Independence".

If "**NO**" to one or more of the above items:

1) Is Self-medication training appropriate? If "**NO**" - Institute preliminary skills training and re-assess in one year.
If "**YES**" - Develop and implement Self-Medication Training Program.

2) Complete "Self-Medication Administration Assessment" Report Page, (page 3 of this form).

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When a client is "Not Independent" qualified persons must administer medications and supervise any self-medication training programs.

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Self-Administration of Medication Assessment Report Page

DESCRIPTIVE INFORMATION (Complete for all clients)

You **MUST** submit this page as part of any Nursing Service Packet. Do **NOT** include any of the previous pages of the Assessment. Retain them for your records.

Client Name: _______________________________ SS# ________-______- ______ Medicaid ID #:______________

Provider:____ ID # _______________DHS Network: ______________

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Program Type: (circle one): CILA (Program 60) ICFDD/MR SNF/Peds

Purchase of Service: Program Code________

INDEPENDENCE: (Complete for all clients. Check only one.)

[ ] **Independent** - Complete "CERTIFICATION OF INDEPENDENCE" immediately below

[ ] **NOT Independent** - Appropriate for self-medication training (Develop and implement Self-Medication Training Program)

[ ] **NOT Independent** - NOT Appropriate for self-medication training (Institute preliminary skills training.)

CERTIFICATION OF INDEPENDENCE (Complete only for persons "Independent.")

I, ____________________________________, (please print) ______/_____/______(Date) being a duly licensed professional registered nurse, do hereby certify that I have reviewed the procedure and documentation used in the self-medication assessment of this individual. I further declare that I have observed the individual perform self-medication tasks in a natural setting and I have indicated my professional opinion regarding this person's capabilities in self-medication and self-medication training as indicated above.

Attach the following document or check the boxes below as appropriate:

Medication Administration Record (MAR) [ ] This individual does not take medications. No MAR is attached.

Treatment Administration Record (TAR) [ ] This individual receives no treatments. No TAR is attached.

Completed by: _____________________________________ **RN** Date: _________/_________/20_______