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| Initial  Update  Re-assessment |  |

**Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS)**

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| **1. GENERAL INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Client First and Last Name:** | | | | | | **Date of Birth:** | | | | | **RIN:** | | | | | | | | | | | **Gender:** | | | | | | | | | **Referral Source:** | | | | | | | | | | | | **Date First Contact:** | | | |
| **Phone Number:** | | | **Primary Language:** | | | | | | | | **Interpreter**  **Services:** | | | | | | | | | | None required  American Sign Language | | | | | | | | | TDD/TYY | | | | | | | | Spoken Language:  Other: | | | | | | | | |
| **Address:** | | | | | | | | | **City:** | | | | | | | | | | | | | | | | **State:** | | | | | | **Zip Code:** | | | | | | | | | | **County:** | | | | | |
| **US Citizen:**  Yes  No | | **Race:** | | | American Indian/Alaska Native  Asian  Black/African American | | | | | | | | | | | Hispanic  Hawaiian Native/Other Pacific Islander  Multi-Race | | | | | | | | | | | | | | | | | | White  Other: | | | | | | | | | | | **Ethnicity:**  Hispanic  Non-Hispanic | |
| **Insurance Coverage and Company:**  N/A | | | | | | | | | | **Household Size:** | | | | | | | **Household Income:** | | | | | | | | **Marital**  **Status:** | | | | Single  Married | | | | | | | Divorced  Domestic Partnership | | | | | | | | | | Widowed |
| **Guardianship**  **Status:** | Own guardian  Biological Parent  Adoptive Parent | | | | | | Youth in Care  Other court appointed  Other: | | | | | | | | | | | **Employment Status:** | | | | | | Self-employed  Student  Homemaker | | | | | | | | | Military  Retired  Unable to work | | | | | | | | | Employed full-time  Employed part-time  Unemployed | | | | |
| **Living**  **Arrangement:** | Lives alone  Independent Living  Lives with parent(s), relative(s), or guardian(s)  State operated facility (mental health/dev. disability)  Jail or correctional facility | | | | | | | | | | | | | | | | | | | | | Residential/Institutional Setting (residential, nursing home, shelter)  Community integrated living arrangement (CILA)  Foster Care  Homeless  Other: | | | | | | | | | | | | | | | | | | | | | | | | |
| **Education Level:**  (last completed) | Never attended  Pre-K/Kindergarten  Grade 1 – 3 | | | | | | | Grade 4 – 5  Grade 6 – 8  Grade 9 – 12 | | | | | | | H.S. diploma/GED  Some college  Associate’s degree | | | | | | | | | | Trade/technical training  Professional certificate  Bachelor’s degree | | | | | | | | | | | | | | Master’s/Doctoral degree | | | | | | | |
| **Parent, Guardian, or**  **Significant Other Info.** | **First and Last Name:** | | | | | | | | | | | | | | | | | | **Relationship to Client:**  Parent  Guardian  Significant Other | | | | | | | | | | | | | | | | | | | | | **Phone Number:** | | | | | | |
| **Address:** | | | | | | | | | | | | **City:** | | | | | | | | | | | | | **State:** | | | | | | **Zip Code:** | | | | | | | | **County:** | | | | | | |
| **Emergency Contact Information** | **First and Last Name:** | | | | | | | | | | | | | | | | | | | **Relationship to Client:** | | | | | | | | | | | | | | | **Phone Number:** | | | | | | | | | | | |
| **Address:** | | | | | | | | | | | | | **City:** | | | | | | | | | | | | | **State:** | | | | | | | | **Zip Code:** | | | | | | | | | | | |
| **Members of**  **Family**  **Constellation** | **Name** | | | | | | | | | | | | | | | | | | | | | | **Age** | | | | | **Relation to Client** | | | | | | | | | | | | | | | | **Living in Home** | | |
|  | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | | | | | | | | | | | | | | Yes  No | | |
|  | | | | | | | | | | | | | | | | | | | | | |  | | | | |  | | | | | | | | | | | | | | | | Yes  No | | |
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| **Established Supports** | | | | **Agency** | | | | | | | | **Contact Name** | | | | | | | | | | | | | | | | **Phone** | | | | | | | | | **Email** | | | | | | | | | |
| Physician | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | |
| School/Daycare | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | |
| Counselor/Therapist | | | |  | | | | | | | | unkn | | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | |
| Child Welfare Worker | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | |
| ISC/PAS Agent | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | |
| Probation Officer | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | |
| Other: | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | |
| Other: | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | |
| Other: | | | |  | | | | | | | |  | | | | | | | | | | | | | | | |  | | | | | | | | |  | | | | | | | | | |

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| **Unless otherwise stated, the following categories and action levels are used throughout to score individual CANS items:** | |
| 0 = No evidence/no reason to believe item requires action.  1 = Watchful waiting, monitoring or preventive action. | 2 = Need for Action. Some strategy is needed to address problem/need.  3 = Immediate/intensive action. Safety concern; priority for intervention. |
| **Please note: Individual CANS items that are not applicable to the entire lifespan have specific age ranges for which the item must be completed indicated in front of the item name.** | |

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| **2. TRAUMA EXPOSURE** | | | | | | | | | | | |
| No = No evidence of any trauma of this type  Yes = Client has, or is suspected of having, at least one incident, multiple incidents or chronic, ongoing experience of this type of trauma | | | | | | | | | | | |
| **POTENTIALLY TRAUMATIC/ADVERSE CHILDHOOD EXPERIENCES (ACEs)** | | | | | | | | | | | |
| **Item** | **No Yes** |  | **Item** | | | | **No Yes** |  | **Item** | | **No Yes** |
| Sexual Abuse |  |  | Medical Trauma | | | |  |  | Victim/Witness to Criminal Activity | |  |
| Physical Abuse |  |  | Natural or Manmade Disaster | | | |  |  | War/Terrorism Affected | |  |
| Neglect |  |  | Witness to Family Violence | | | |  |  | Disruptions in Caregiving/ Attachment Losses | |  |
| Emotional Abuse |  |  | Witness to Community/School Violence | | | |  |  | Parental Criminal Behavior | |  |
| **Supporting Information:** Provide additional information on the type of trauma experienced by the client (items rated YES) and the age of occurrence. | | | | | | | | | | | |
| **3. PRESENTING PROBLEM AND IMPACT ON FUNCTIONING** | | | | | | | | | | | |
| **3a. Presenting Situation and Presenting Symptoms** | | | | | | | | | | | |
| **BEHAVIORAL/EMOTIONAL NEEDS** | | | | **n/a 0 1 2 3** |  |  | | | | **n/a 0 1 2 3** | |
| Depression | | | |  |  | 3+: Impulsivity/Hyperactivity | | | |  | |
| Anxiety | | | |  |  | 3+: Anger Control/Frustration Tolerance | | | |  | |
| Eating Disturbance | | | |  |  | 6+: Substance Use [L – see p. 5] | | | |  | |
| Adjustment to Trauma [A – see below] | | | |  |  | 6+: Psychosis (Thought Disorder) | | | |  | |
| 0-6: Regulatory | | | |  |  | 6+: Conduct/Antisocial Behavior | | | |  | |
| 0-6: Failure to Thrive | | | |  |  | 16+: Interpersonal Problems | | | |  | |
| 0-6: Atypical/Repetitive Behaviors [B – p. 3] | | | |  |  | 21+: Mania | | | |  | |
| 3-18: Oppositional (Non-compl. w/ auth.) | | | |  |  | 21+: Somatization | | | |  | |
| **[A] TRAUMATIC STRESS SYMPTOMS MODULE** (To complete when Behavioral/Emotional Needs, Adjustment to Trauma item is rated 1, 2 or 3) | | | | | | | | | | | |
| **Item** | | | | **0 1 2 3** |  | **Item** | | | | **0 1 2 3** | |
| *Emotional and/or Physical Dysregulation* | | | |  |  | *Traumatic Grief & Separation* | | | |  | |
| *Intrusions/Re-experiencing* | | | |  |  | *Numbing* | | | |  | |
| *Hyperarousal* | | | |  |  | *Dissociation* | | | |  | |
| *Attachment Difficulties* | | | |  |  | *Avoidance* | | | |  | |

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| **3b. Impact of Problems on Client’s Functioning** | | | | |
| **LIFE FUNCTIONING** | **n/a 0 1 2 3** |  |  | **n/a 0 1 2 3** |
| Family Functioning |  |  | 0-6: Elimination |  |
| Living Situation |  |  | 0-21: School/Preschool/Daycare [C – see p. 3] |  |
| Residential Stability |  |  | 3+: Decision Making |  |
| Social Functioning |  |  | 6+: Legal [K – see p. 4] |  |
| Recreation/Play |  |  | 6+: Sexual Development |  |
| Developmental/Intellectual [B – see p. 3] |  |  | 16+: Job Functioning/Employment [D – see p. 3] |  |
| Communication |  |  | 16+: Parental/Caregiving Role [E – see p. 3] |  |
| Medical/Physical |  |  | 16+: Independent Living Skills [F – see p. 3] |  |
| Medication Compliance |  |  | 16+: Intimate Relationships |  |
| Transportation |  |  | 21+: Basic Activities of Daily Living |  |
| 1+: Sleep |  |  | 21+: Routines |  |
| 0-6: Motor |  |  | 21+: Functional Communication |  |
| 0-6: Sensory |  |  | 21+: Loneliness |  |
| 0-6: Persistence/Curiosity/Adaptability |  |  |  |  |

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| **[B] DEVELOPMENTAL DISABILITIES MODULE** (To complete when Life Functioning Domain, Developmental/Intellectual item or Emotional/Behavioral Needs Domain, Atypical/Repetitive Behaviors item is rated 1, 2 or 3) | | | | | | | | | | |
| **Item** | | | **n/a 0 1 2 3** |  | **Item** | | | | **n/a 0 1 2 3** | |
| *Cognitive* | | |  |  | *6+: Sensory* | | | |  | |
| *Developmental* | | |  |  | *6+: Motor* | | | |  | |
| *Self-Care/Daily Living Skills* | | |  |  | *6+: Regulatory* | | | |  | |
| *Autism Spectrum* | | |  |  |  | | | |  | |
| **[C] SCHOOL/PRESCHOOL/DAYCARE MODULE** (To complete when Life Functioning Domain, School/Preschool/Daycare item is rated 1, 2 or 3) | | | | | | | | | | |
| **Item** | | | **n/a 0 1 2 3** |  | **Item** | | | | **n/a 0 1 2 3** | |
| *School/Preschool/Daycare Behavior* | | |  |  | *Relationships with Teachers* | | | |  | |
| *School/Preschool/Daycare Achievement* | | |  |  | *Preschool/Daycare Quality* | | | |  | |
| *School/Preschool/Daycare Attendance* | | |  |  |  | | | |  | |
| **School Needs:** | Educational Testing | GED or Credit Recovery | | | | Student Study Team | 504 Plan | IEP | | Tutoring |
| **[D] VOCATIONAL AND CAREER MODULE** (To complete when Life Functioning Domain, Job Functioning/Employment item is rated 1, 2 or 3) | | | | | | | | | | |
| **Item** | | | **0 1 2 3** |  | **Item** | | | | **0 1 2 3** | |
| *Career Aspirations* | | |  |  | *Job Performance* | | | |  | |
| *Job Time* | | |  |  | *Job Relations* | | | |  | |
| *Job Attendance* | | |  |  | *Job Skills* | | | |  | |
| **[E] PARENTING/CAREGIVING MODULE** (To complete when Life Functioning Domain, Parental/Caregiving Role item is rated 1, 2 or 3) | | | | | | | | | | |
| **Item** | | | **0 1 2 3** |  | **Item** | | | | **0 1 2 3** | |
| *Knowledge of Needs* | | |  |  | *Organization* | | | |  | |
| *Supervision* | | |  |  | *Marital/Partner Violence In the Home* | | | |  | |
| *Involvement with Care* | | |  |  |  | | | |  | |
| **[F] INDEPENDENT ACTIVITIES OF DAILY LIVING MODULE** (To complete when Life Functioning Domain, Independent Living Skills item is rated 1, 2 or 3) | | | | | | | | | | |
| **Item** | | | **0 1 2 3** |  | **Item** | | | | **0 1 2 3** | |
| *Meal Preparation* | | |  |  | *Money Management* | | | |  | |
| *Shopping* | | |  |  | *Communication Device Use* | | | |  | |
| *Housework* | | |  |  | *Housing Safety* | | | |  | |
| **Supporting Information:** Provide additional information regarding presenting situation and symptoms (Emotional/Behavioral items rated 2 and 3). Information on the impact of the presenting situation on the client’s functioning (Life Functioning items rated 2 and 3) should also be included in the narrative. If Modules A-F are completed, please include items rated 2 and 3 in the narrative. | | | | | | | | | | |
| Symptoms:  Dx:  .  Hospitalized for mental health --  Med Concerns--  Started, Triggers  Previous Tx  Sec A: Trauaa  Sec L: Substance use -  Family Fact  REsidential Stability  Recreation / play | | | | | | | | | | |

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| **4. SAFETY** | | | | |
| **4a. Risk Behaviors** | | | | |
| **RISK BEHAVIORS** | **n/a 0 1 2 3** |  |  | **n/a 0 1 2 3** |
| Victimization/Exploitation |  |  | 6+: Delinquent/Criminal Behavior [K – see p. 4] |  |
| 0-6: Self-Harm |  |  | 6+: Non-Suicidal Self-Inj. Beh. (Self-Mutilation) |  |
| 3-6: Flight Risk |  |  | 6+: Other Self-Harm (Recklessness) |  |
| 3+: Suicide Risk |  |  | 6+: Danger to Others [I – see p. 4] |  |
| 3+: Intentional Misbehavior |  |  | 6+: Fire Setting [J – see p. 4] |  |
| 6-21: Runaway [G – see p. 4] |  |  | 21+: Grave Disability |  |
| 6+: Sexually Prob. Behavior [H – see p. 4] |  |  | 21+: Hoarding |  |
| 6+: Bullying Others |  |  |  |  |
| **[G] RUNAWAY MODULE** (To complete when Risk Behaviors Domain, Runaway item is rated 1, 2 or 3) | | | | |
| **Item** | **0 1 2 3** |  | **Item** | **0 1 2 3** |
| *Frequency of Running* |  |  | *Likelihood of Return on Own* |  |
| *Consistency of Destination* |  |  | *Involvement of Others* |  |
| *Safety of Destination* |  |  | *Realistic Expectations* |  |
| *Involvement in Illegal Acts* |  |  | *Planning* |  |
| **[H] – SEXUALLY PROB. BEH. MODULE** (To complete when Risk Behaviors Domain, Sexually Problematic Behavior item is rated 1, 2 or 3) | | | | |
| **Item** | **0 1 2 3** |  | **Item** | **0 1 2 3** |
| *Hypersexuality* |  |  | *Sexual Aggression [H1 – see below]* |  |
| *High Risk Sexual Behavior* |  |  | *Sexually Reactive Behavior* |  |
| *Masturbation* |  |  |  |  |
| **[H1] SEXUALLY AGGR. BEH. SUB-MODULE** (To complete when Sexually Prob. Beh. Module, Sexual Aggression item is rated 1, 2 or 3) | | | | |
| **Item** | **0 1 2 3** |  | **Item** | **0 1 2 3** |
| *Relationship* |  |  | *Power Differential* |  |
| *Physical Force/Threat* |  |  | *Type of Sex Act* |  |
| *Planning* |  |  | *Response to Accusation* |  |
| *Age Differential* |  |  |  |  |

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| **[I] DANGEROUSNESS MODULE** (To complete when Risk Behaviors Domain, Danger to Others item is rated 1, 2 or 3) | | | | | |
| **Item** | **0 1 2 3** |  | **Item** | **0 1 2 3** | |
| *Hostility* |  |  | *Planning* |  | |
| *Paranoid Thinking* |  |  | *Violence History* |  | |
| *Secondary Gains from Anger* |  |  | *Aware of Violence Potential* |  | |
| *Violent Thinking* |  |  | *Response to Consequences* |  | |
| *Intent* |  |  | *Commitment to Self-Control* |  | |
| **[J] FIRE SETTING MODULE** (To complete when Risk Behaviors Domain, Fire Setting item is rated 1, 2 or 3) | | | | | |
| **Item** | **0 1 2 3** |  | **Item** | **0 1 2 3** | |
| *Seriousness* |  |  | *Community Safety* |  | |
| *History* |  |  | *Response to Accusation* |  | |
| *Planning* |  |  | *Remorse* |  | |
| *Use of Accelerants* |  |  | *Likelihood of Future Fire Setting* |  | |
| *Intention to Harm* |  |  |  |  | |
| **Supporting Information:** Provide additional information regarding the client’s risk behaviors, including aggressive/violent behavior/danger to others (items rated 2 and 3), and the level of impairment (e.g., school suspension, law enforcement involvement, crisis services, hospitalization). | | | | | |
| **[K] JUSTICE/CRIME MODULE** (To complete when Life Functioning Domain, Legal item or Risk Behaviors Domain, Delinq./Criminal Beh. item is rated 1, 2 or 3) | | | | | |
| **Item** | **0 1 2 3** |  | **Item** | | **0 1 2 3** |
| *Seriousness* |  |  | *Community Safety* | |  |
| *History* |  |  | *Legal Compliance* | |  |
| *Arrests* |  |  | *Peer Influences* | |  |
| *Planning* |  |  | *Environmental Influences* | |  |
| **Has the client ever been found by a criminal court to be:** *(check all that apply)* | | | | | |
| Unfit to Stand Trial (UST)?  Yes  No | | | Date(s) of UST finding: | | |
| Not Guilty by Reason of Insanity (NGRI)?  Yes  No | | | Date(s) of NGRI finding: | | |
| **Supporting Information:** Provide additional information regarding client’s current and previous legal involvement, including any items rated 2 and 3 in the Justice/Crime Module. Include information on any findings of UST or NGRI, including whether the charges were for a misdemeanor or a felony. | | | | | |

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| **4b. Factors in Current Environment** |
| Identify the factors in the client’s current environment that may create threats to the client’s personal safety (e.g., gang involvement, domestic violence, active abuse, access to weapons, etc.). |

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| **5. SUBSTANCE USE HISTORY** | | | | | | | |
| **[L] SUBSTANCE USE MODULE (To complete when Behavioral/Emotional Needs, Substance Use item is rated 1, 2 or 3)** | | | | | | | |
| **Item** | | **0 1 2 3** | |  | **Item** | | **n/a 0 1 2 3** |
| *Severity of Use* | |  | |  | *Peer Influences* | |  |
| *Duration of Use* | |  | |  | *0-21: Parental Influences* | |  |
| *Stage of Recovery* | |  | |  | *21+: Recovery Support in Community* | |  |
| *Environmental Influences* | |  | |  |  | |  |
| **Supporting Information:** Provide additional information on client’s substance/alcohol abuse (including Substance Use Module items rated 2 and 3, if completed). Specify onset, type – including tobacco and caffeine – frequency, amount and level of impairment (e.g., missing work/school, law enforcement/incarceration, family’s level of concern and attempts to intervene). | | | | | | | |
|  | | | | | | | |
| **Prior Substance Abuse Treatment:**  Yes  No | | | | | | | |
| **When** | **Where** | | **With Whom** | | | **Reason** | |
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| **6. PLACEMENT HISTORY** | | | | | | | | | | | | | | | | | | |
| Describe previous and current out-of-home placements for the client including shelters, foster care, group home, nursing home, detention/incarceration, etc.  Client has not had any out of home placements. | | | | | | | | | | | | | | | | | | |
| **7. PSYCHIATRIC INFORMATION** | | | | | | | | | | | | | | | | | | |
| **7a. Psychiatric Problems** | | | | | | | | | | | | | | | | | | |
| Describe significant psychiatric problems, treatments, and outcomes. | | | | | | | | | | | | | | | | | | |
| **7b. General Mental Health History** | | | | | | | | | | | | | | | | | | |
| **Prior psychological assessment**:  Yes  No Date:       IQ: | | | | | | | | | | | | **Prior psychiatric evaluation**:  Yes  No Date: | | | | | | |
| **Assessment Needs:**  Psychological Testing  Psychiatric Evaluation | | | | | | | | | | | | **Prior Outpatient Mental Health Services:**  Yes  No | | | | | | |
| **When** | | **Where** | | | | | **With Whom** | | | | | | | **Reason** | | | | |
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| **7c. Mental Status:** Document clinical observations to support client’s current mental status as noted below. | | | | | | | | | | | | | | | | | | |
| Appearance and Behavior: | | | | | | | | | | | | | | | | | | |
| Threatening: | Yes | | No | Mood: | | | WNL | | Depressed | | | | Manic | | Anxious | Angry | | |
| Suicidal: | Yes | | No | Expansive | | Labile | | | |  | | | | | |
| Homicidal: | Yes | | No | Affect: | | | WNL | | Sad | | | | Angry | | Flat | Constricted | | |
| Impulse Control: | Poor | | Good | Inappropriate | | | | | | | | | | | |
| Hallucinatory: | Yes | | No | Insight: | | | Good | | Fair | | | | Poor | | | | | |
| Delusional: | Yes | | No | Orientation: | | | WNL | | Impaired | | | |  | | | | | |
| Judgment: | WNL | | Impaired | Cognition: | | | WNL | | Loose Associations/Disorganized | | | | | | | | | |
| Memory: | WNL | | Impaired | **Please note: WNL = Within Normal Limits** | | | | | | | | | | | | | | |
| **8. CLIENT STRENGTHS 0 = Centerpiece Strength 1 = Useful Strength 2 = Identified Strength 3 = Not Yet Identified Strength** | | | | | | | | | | | | | | | | | | |
| **CLIENT STRENGTHS** | | | | | | **n/a 0 1 2 3** | |  | | |  | | | | | | | **n/a 0 1 2 3** |
| Family Strengths/Support | | | | | |  | |  | | | 6+: Talents and Interests | | | | | | |  |
| Interpersonal/Social Connectedness | | | | | |  | |  | | | 6+: Cultural Identity | | | | | | |  |
| Natural Supports | | | | | |  | |  | | | 6+: Community Connection | | | | | | |  |
| Spiritual/Religious | | | | | |  | |  | | | 6+: Involvement with Care | | | | | | |  |
| Educational Setting | | | | | |  | |  | | | 16+: Vocational | | | | | | |  |
| 0-21: Relationship Permanence | | | | | |  | |  | | | 16+: Job History/Volunteering | | | | | | |  |
| 2+: Resiliency | | | | | |  | |  | | | 21+: Self-Care | | | | | | |  |
| 6+: Optimism | | | | | |  | |  | | |  | | | | | | |  |
| **Supporting Information:** Provide additional information on client’s strengths (items rated 0 and 1) – the aspects of the community and people in the client’s network that provide support, and traits of the client that he/she has used to achieve his/her goals. | | | | | | | | | | | | | | | | | | |
| **9. FAMILY INFORMATION** | | | | | | | | | | | | | | | | | | |
| **9a. Relevant Family History** | | | | | | | | | | | | | | | | | | |
| Describe precipitating and other significant life events leading to current situation (e.g., divorce, immigration, level of acculturation/assimilation, losses, moves, financial difficulties, etc.). Please include: 1) family history of mental illness, 2) current court involvement (client and family). | | | | | | | | | | | | | | | | | | |
| **9b. Cultural Considerations** | | | | | | | | | | | | | | | | | | |
| **CULTURAL FACTORS** | | | | | **0 1 2 3** | | |  | |  | | | | | | | **0 1 2 3** | |
| Language | | | | |  | | |  | | Cultural Stress | | | | | | |  | |
| Traditions and Rituals | | | | |  | | |  | |  | | | | | | |  | |
| **Supporting Information:** Provide additional information regarding the cultural factors (items rated 2 and 3) that may influence presenting problems (e.g., ethnicity, race, religion, spiritual practice, sexual orientation, transgender, socioeconomic status, living environment, etc.). | | | | | | | | | | | | | | | | | | |

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| **10. NEEDS/RESOURCE ASSESSMENT**  None. No additional needs/resources identified. | | | | |
| Access to Food | Educational Testing | Mentoring | Financial Assistance | Immigration Assistance |
| Clothing | Employment | Legal Assistance | Physical Health | Mental Health Service |
| Shelter | Other (specify): |  |  |  |

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| **11. DIAGNOSIS** | | |  |  | |
| **DSM-5 Diagnosis:** | | **ICD- 10 Diagnosis:** | | | **Preventive** |
| Diagnostic Code | DSM-5 Name | Diagnostic Code | ICD-10 Name | | **Diagnosis** |
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| **12. MENTAL HEALTH ASSESSMENT SUMMARY** |
| Summary analysis and conclusion regarding the medical necessity of services. Tie all key information about the client’s mental health needs and diagnosis here. |
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| **13. ADDITIONAL CLIENT FUNCTIONING EVALUATIONS RECOMMENDED BY LPHA:**  No additional evaluations |
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| **14. SUMMARY OF PRIORITIZED CANS NEEDS AND STRENGTHS** | | | | |
| **14a. CANS Actionable Items to Consider for Treatment Planning** | | | | |
| **Background – Trauma Experiences** | |  | **Background – Other Needs** | |
| Item: | Y  N |  | Item: | 2  3 |
| Item: | Y  N |  | Item: | 2  3 |
| Item: | Y  N |  | Item: | 2  3 |
| **Treatment Target Needs** | |  | **Anticipated Outcome Needs** | |
| Item: | 2  3 |  | Item: | 2  3 |
| Item: | 2  3 |  | Item: | 2  3 |
| Item: | 2  3 |  | Item: | 2  3 |
| Item: | 2  3 |  | Item: | 2  3 |
| Item: | 2  3 |  | Item: | 2  3 |
| **Centerpiece/Useful Strengths** | |  | **Strengths to Build** | |
| Item: | 0  1 |  | Item: | 2  3 |
| Item: | 0  1 |  | Item: | 2  3 |
| Item: | 0  1 |  | Item: | 2  3 |
| Item: | 0  1 |  | Item: | 2  3 |
| **Caregiver Resources** | |  | **Caregiver Needs** | |
| Item: | 0  1 |  | Item: | 2  3 |
| Item: | 0  1 |  | Item: | 2  3 |
| Item: | 0  1 |  | Item: | 2  3 |

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| **15. INDIVIDUAL TREATMENT PLAN** |
| **15a. Client and Family Vision Statement For Treatment** |
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| **15b. Client and Family Service Preferences.** |
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| **16. Treatment Goals and Objectives Treatment Plan Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | |
| All treatment goals and objectives should be stated in client/family language and should relate back to the CANS actionable items identified in box 14a. Goals are specific, observable outcomes related to functioning that result from targeting symptoms and behaviors. Objectives are the specific steps to reach the goal. | | |
| **CANS Item(s):**  **CLIENT GOAL 1:** | | **Goal Status:**  Continue  Discontinue  Completed Date: |
| **Clinical Objectives** | | |
| Objective  1a. |  | |
| Objective  1b. |  | |
| Objective  1c. |  | |
| **CANS Item(s):**  **CLIENT GOAL 2:** | | **Goal Status:**  Continue  Discontinue  Completed Date: |
| **Clinical Objectives** | | |
| Objective  2a. |  | |
| Objective  2b. |  | |
| Objective  2c. |  | |
| **CANS Item(s):**  **CLIENT GOAL 3:** | | **Goal Status:**  Continue  Discontinue  Completed Date: |
| **Clinical Objectives** | | |
| Objective  3a. |  | |
| Objective  3b. |  | |
| Objective  3c. |  | |
| **CANS Item(s):**  **CLIENT GOAL 4:** | | **Goal Status:**  Continue  Discontinue  Completed Date: |
| **Clinical Objectives** | | |
| Objective  4a. |  | |
| Objective  4b. |  | |
| Objective  4c. |  | |
| **CANS Item(s):**  **CLIENT GOAL 5:** | | **Goal Status:**  Continue  Discontinue  Completed Date: |
| **Clinical Objectives** | | |
| Objective  5a. |  | |
| Objective  5b. |  | |
| Objective  5c. |  | |

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| **Use the service key and mode key below to complete the service section of the treatment plan. For services not listed, please indicate “Other” in the Service Type line and specify the services/interventions to be pursued.** | | | | | | | | | | | |
| **SERVICE TYPE** | **KEY** | | **SERVICE TYPE** | | | **KEY** | **SERVICE TYPE** | **KEY** | | **SERVICE TYPE** | **KEY** |
| Therapy/Counseling | TC | | Assertive Comm. Treatment | | | ACT | Case Mgmt -Transition Linkage, Aftercare | TLA | | Psych Med Administration | PMA |
| Community Support | CS | | Case Mgmt -Mental Health | | | MH | Mental Health Intensive Outpatient | IO | | Psych Med Monitoring | PMM |
| Community Support Team | CST | | Case Mgmt -Client Centered Consultation | | | CCC | Psychosocial Rehabilitation | PSR | | Psych Med Training | PMT |
| **SERVICE MODE KEY** | | | | | | | **PLACE OF SERVICE KEY** | | | | |
| Individual= I | | Group= G | | Family= F | Residential= R | | On-Site= ON | | Off-Site= OFF | | |

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| **17. Services/Interventions** | | | | | | | |
| **Objective(s)** | **Service Type** | **Mode** | **Place of Service** | **Amount** | **Frequency** | **Duration** | **Agency and Staff Responsible** |
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| **IM+CANS SIGNATURES** | | | | | | | |
| By signing this you agree that you have participated in the mental health assessment and treatment planning process and have been given a copy of the completed IM+CANS. You agree that you have had a chance to review the IM+CANS in full, and that the contents have been explained to you in a language that you understand. You understand the risks and benefits of the services outlined in the treatment plan and consent to the services as outlined in this plan. **Please document if a youth 12 years of age or older refuses to sign.** | | | | | | | |
| **CLIENT SIGNATURE (required for all clients 12 years of age or older)** | | | | **PARENT/LEGAL GUARDIAN SIGNATURE** | | | |
| Client (print name) | Signature | | Date (mm/dd/yyyy) | Parent/Legal Guardian (print name) | Signature | | Date (mm/dd/yyyy) |
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| **STAFF RESPONSIBLE FOR IM+CANS DEVELOPMENT, REVIEW, AND MODIFICATION SIGNATURE** | | | | | | | |
| Staff Completing (print name) | | Credentials | | LPHA Authorizer (print name) | | Credentials | |
|  | |  | |  | |  | |
| Signature | | Date (mm/dd/yyyy) | | Signature | | Date (mm/dd/yyyy) | |
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