

HEALTHCARE AND FAMILY SERVICES

(IM + CANS)

Illinois Medicaid Comprehensive Assessment of Needs and Strengths

Version :

CANS TYPE

Initial

Re - assessment

Discharge

Status :

1. General Information

Individual Name :

Date Of Birth :

Gender :

Phone Number :

Address :

City :

State :

Zip Code :

Ethnicity :

Race :

Marital Status :

RIN :

Referral Source :

Date First Contact :

Primary Language :

County :

Interpreter Services :

Interpreter Other Description :

US Citizen : Yes No

Insurance Coverage and Company :

Insurance Company :

DCFS Youth : Yes No

Caregiver : Yes No

Household Size :

Household Income :

Guardian Status :

Guardian Status Other :

Living Arrangement Other :

Employment Status :

Living Arrangement :

Education Level :

Parent, Guardian, or Significant Other

First Name :

Last Name :

Phone Number :

State :

Zip Code :

Relationship To Client :

Parent

Guardian

significant other

City :

Address :

Emergency Contact Information

First Name :

Last Name :

Phone Number :

State :

Zip Code :

Relationship To Client :

City :

Address :

Members of Family Constellation

Name	Age	Result to Client	Living in Home
No Records			

Established Supports	Agency	Contact Name	Phone	Email
No Records				

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 .

Sexual Abuse :	Yes	No	Medical Trauma :	Yes	No
Victim/witness to Criminal Activity :	Yes	No	Physical Abuse :	Yes	No
Natural or Manmade Disaster :	Yes	No	War / Terrorism Affected :	Yes	No
Neglect :	Yes	No	Witness to Family Violence :	Yes	No
Disruptions in Caregiving / Attachment Losses :	Yes	No	Emotional Abuse :	Yes	No
Witness to Community / School Violence :	Yes	No	Parental Criminal Behavior :	Yes	No

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

0 = No evidence / no reason to believe the item requires action .

1 = Watchful waiting, monitoring or preventive action.

2 = Need for Action . Some strategy is needed to address problems / needs .

3 = Immediate / intensive action. Safety concern ; priority for intervention.

3a . Presenting Situation and presenting Symptoms

BEHAVIORAL / EMOTIONAL NEEDS

Depression :

0 1 2 3

Anxiety :

0 1 2 3

Eating Disturbance :

0 1 2 3

Adjustment to Trauma [A - see below]

0 1 2 3

0 - 6 Regulatory

0 1 2 3

0 - 6 : Failure to Thrive

0 1 2 3

0 - 6 : Atypical / Repetitive Behaviors [B - p.3]

0 1 2 3

3 - 18 : Oppositional (Non - comp. w / auth.)

0 1 2 3

3 + : Impulsivity / Hyperactivity

0 1 2 3

3 + : Anger Control / Frustration Tolerance

0 1 2 3

6 + : Substance Use [L - see p.5]

0 1 2 3

6 + : Psychosis (Thought Disorder)

0 1 2 3

6 + : Conduct / Antisocial Behavior

0 1 2 3

16 + : Interpersonal Problems

0 1 2 3

21 + : Mania

0 1 2 3

21 + : Somatization

0 1 2 3

[A] TRAUMATIC STRESS SYMPTOMS MODULE

(To Complete when Behavioral / Emotional Needs, Adjustment to Trauma item is rated 1, 2 or 3).

Emotional and / or Physical Dysregulation

0 1 2 3

Intrusions / Re - Experiencing

0 1 2 3

Hyperarousal

0 1 2 3

Attachment Difficulties

0 1 2 3

Traumatic Grief & Separation

0 1 2 3

Numbing

0 1 2 3

Dissociation

0 1 2 3

Avoidance

0 1 2 3

3b. Impact of Problems on Client's Functioning**LIFE FUNCTIONING****Family Functioning**

0 1 2 3

Living Situation

0 1 2 3

Residential Stability

0 1 2 3

Social Functioning

0 1 2 3

Recreation / Play

0 1 2 3

Developmental / Intellectual [B - see p. 3]

0 1 2 3

Communication

0 1 2 3

Medical / Physical

0 1 2 3

Medication Compliance

0 1 2 3

Transportation

0 1 2 3

1 + : Sleep

0 1 2 3

0 - 6 : Motor

0 1 2 3

0 - 6 : Sensory

0 1 2 3

0 - 6 : Persistence / Curiosity / Adaptability

0 1 2 3

0 - 6 : Elimination

0 1 2 3

0 - 21 : School / Preschool / Daycare [C - see p.3]

0 1 2 3

3 + : Decision Making

0 1 2 3

6 + : Legal [K - see p.4]

0 1 2 3

6 + : Sexual Development

0 1 2 3

16+ : Job Functioning / Employment [D - see p.3]

0 1 2 3

16+ : Parental / Caregiving Role [E - see p.3]

0 1 2 3

16+ : Independent Living Skills [f - see p.3]

0 1 2 3

16+ : Intimate Relationships

0 1 2 3

21+ : Basic Activities of Daily Living

0 1 2 3

21 + : Routines

0 1 2 3

21+ : Functional Communication

0 1 2 3

21+ : Loneliness

0 1 2 3

[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)

Cognitive

0 1 2 3

6 + : Sensory

0 1 2 3

Developmental
0 1 2 3

Self - Care / Daily Living Skills
0 1 2 3

Autism Spectrum
0 1 2 3

6 + : Motor
0 1 2 3

6 + : Regulatory
0 1 2 3

[C] SCHOOL / PRESCHOOL / DAYCARE MODULE (To Complete when Life Functioning Domain, School / Preschool / Daycare item is rated 1, 2 or 3)

School / Preschool / Daycare Behavior
0 1 2 3

Relationships with Teachers
0 1 2 3

School / Preschool / Daycare Achievement
0 1 2 3

Preschool / Daycare Quality
0 1 2 3

School / Preschool / Daycare Attendance
0 1 2 3

[D] VOCATIONAL AND CAREER MODULE (To complete when Life Functioning, Job Functioning / Employment item is rated 1, 2 or 3)

Career Aspirations
0 1 2 3

Job Performance
0 1 2 3

Job Time
0 1 2 3

Job Relations
0 1 2 3

Job Attendance
0 1 2 3

Job Skills
0 1 2 3

[E] PARENTING / CAREGIVING MODULE (To Complete when Life functioning domain, Parental / Caregiving Role item is rated 1, 2 or 3)

Knowledge of Needs
0 1 2 3

Organization
0 1 2 3

Supervision
0 1 2 3

Marital / Partner Violence in the Home
0 1 2 3

Involvement with Care
0 1 2 3

[F] INDEPENTENT ACTIVITIES OF DAILY LIVING MODULE (To complete when Life Functioning Domain, Independent Living Skills item is rated 1, 2 or 3)

Meal Preparation
0 1 2 3

Money Management
0 1 2 3

Shopping
0 1 2 3

Communication Device Use
0 1 2 3

Housework
0 1 2 3

Housing Safety
0 1 2 3

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.

4. SAFETY

0 = No Evidence / no reason to believe the item requires action.

1 = Watchful waiting, monitoring or preventive action.

2 = Need for Action . Some Strategy is needed to address problems / needs .

3. Immediate / intensive action . Safety concern; Priority for intervention.

4a. Risk Behaviors

RISK BEHAVIORS

Victimization / Exploitation

0 1 2 3

0 - 6 : Self - Harm

0 1 2 3

3 - 6 : Flight Risk

0 1 2 3

3+ : Suicide Risk

0 1 2 3

3+ : Intentional Misbehavior

0 1 2 3

6 - 21 : Runway [G - see p.4]

0 1 2 3

6+ : Sexually Prob. Behavior [H - see p.4]

0 1 2 3

6+ : Bullying Others

0 1 2 3

6+ : Delinquent / Criminal Behavior [K - see p.4]

0 1 2 3

6+ : Non - Suicidal Self - Inj. Beh. (Self - Mutilation)

0 1 2 3

6+ : Other Self - Harm (Recklessness)

0 1 2 3

6+:Danger to Others [I - see p.4]

0 1 2 3

6+ : Fire Setting [J - see p.4]

0 1 2 3

21+ : Grave Disability

0 1 2 3

21+ : Hoarding

0 1 2 3

[G] RUNWAY MODULE (To Complete When Risk Behaviors Domain, Runway item it rated 1, 2 or 3)

Frequency of Running

0 1 2 3

Consistency of Destination

0 1 2 3

Safety of Destination

0 1 2 3

Involvement in Illegal Acts

0 1 2 3

Likelihood of Return on Own

0 1 2 3

Involvement of Others

0 1 2 3

Realistic Expectations

0 1 2 3

Planning

0 1 2 3

[H] - SEXUALLY PROB. BEH. MODULE (To Complete When Risk Behaviors Domain, Sexually Problematic Behavior item is rated 1, 2 or 3)

Hypersexuality

0 1 2 3

High Risk Sexual Behavior

0 1 2 3

Masturbation

0 1 2 3

Sexual Aggression [H1 - see below]

0 1 2 3

Sexually Reactive Behavior

0 1 2 3

[H1] SEXUALLY AGGR. BEH. SUB - MODULE (To complete when Sexually Prob. Beh. Module, Sexual Aggression item is rated 1, 2 or 3)

Relationship

0 1 2 3

Physical Force / Threat

0 1 2 3

Power Differential

0 1 2 3

Type of Sex Act

0 1 2 3

Planning 0 1 2 3	Response to Accusation 0 1 2 3
Age Differential 0 1 2 3	

[I] DANGEROUSNESS MODULE (To Complete when Risk Behaviors Domain, Danger to Others item is rated 1, 2 or 3)							
Hostility 0 1 2 3				Planning 0 1 2 3			
Paranoid Thinking 0 1 2 3				Violence History 0 1 2 3			
Secondary Gains From Anger 0 1 2 3				Aware of Violence Potential 0 1 2 3			
Violent Thinking 0 1 2 3				Response to Consequences 0 1 2 3			
Intent 0 1 2 3				Commitment to Self - Control 0 1 2 3			

[J] FIRE SETTING MODULE (To Complete when Risk Behaviors Domain, Fire Setting item is rated 1, 2 or 3)							
Seriousness 0 1 2 3				Community Safety 0 1 2 3			
History 0 1 2 3				Response to Accusation 0 1 2 3			
Planning 0 1 2 3				Remorse 0 1 2 3			
Use of Accelerants 0 1 2 3				Likelihood of Future Fire Setting 0 1 2 3			
Intention to Harm 0 1 2 3							

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)							
Seriousness 0 1 2 3				Community Safety 0 1 2 3			
History 0 1 2 3				Legal Compliance 0 1 2 3			
Arrests 0 1 2 3				Peer Influences 0 1 2 3			
Planning 0 1 2 3				Environmental Influences 0 1 2 3			

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.

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.).

5. SUBSTANCE USE HISTORY

- 0 = No evidence/no reason to believe the item requires action.**
1 = Watchful waiting, monitoring or preventive action.
2 = Need for Action. Some strategy is needed to address problems/needs.
3 = Immediate/intensive action. Safety concern; priority for intervention.

[L] SUBSTANCE USE MODULE (To complete when Behavioral/Emotional Needs, Substance Use item is rated 1, 2 or 3)

Severity of Use

0 1 2 3

Duration of Use

0 1 2 3

Stage of Recovery

0 1 2 3

Environmental Influences

0 1 2 3

Peer Influences

0 1 2 3

0-21: Parental Influences

0 1 2 3

21+: Recovery Support in Community

0 1 2 3

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
No Records			

6. PLACEMENT HISTORY

Client has not had any out of home placements.

Describe previous and current out-of-home placements for the client including shelters, foster care, group home, nursing home, detention/incarceration, etc

7. PSYCHIATRIC INFORMATION

7a. Psychiatric Problems Describe previous and current out-of-home placements for the client including shelters, foster care, group home, nursing home, detention/incarceration, etc
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Describe previous and current out-of-home placements for the client including shelters, foster care, group home, nursing home, detention/incarceration, etc

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
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When	Where	With Whom	Reason
sdfd			

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
sdfd			

7c. Mental Status :									
Document clinical observations to support client's current mental status as noted below.									
Appearance and Behavior :									
Threatening :		Yes	No			Suicidal :		Yes	No
Homicidal :		Yes	No			Impulse Control :		Poor	Good
Hallucinatory :		Yes	No			Delusional :		Yes	No
Judgment :		WNL	Impaired			Memory :		WNL	Impaired
Mood :									
WNL	Depressed	Manic	Anxious	Angry	Expansive	Labile			
Affect :									
WNL	Sad	Angry	Flat	Constricted	Inappropriate	Depressed	Manic	Anxious	
Insight :		Good	Fair	Poor	Orientation :		WNL	Impaired	
Cognition :		WNL	Loose Associations / Disorganized						

Appearance and Behavior :

Threatening :	Yes	No
Homicidal :	Yes	No
Hallucinatory :	Yes	No
Judgment :	WNL	Impaired

Suicidal :	Yes	No
Impulse Control :	Poor	Good
Delusional :	Yes	No
Memory :	WNL	Impaired

Mood : WNL Depressed Manic Anxious Angry Expansive Labile

Affect :	WNL	Sad	Angry	Flat	Constricted	Inappropriate	Depressed	Manic	Anxious
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[illegible]

Cognition : WNL Loose Associations / Disorganized

8. CLIENT STRENGTHS

Family Strengths / Support :

Centerpiece Strength	Useful Strength	Identified Strength	Not Yet Identified Strength
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6+: Talents and Interests :

Centerpiece Strength	Useful Strength	Identified Strength	Not Yet Identified Strength
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Interpersonal/Social Connectedness :

Centerpiece Strength	Useful Strength	Identified Strength	Not Yet Identified Strength
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6+: Cultural Identity :

Centerpiece Strength	Useful Strength	Identified Strength	Not Yet Identified Strength
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Natural Supports :

Centerpiece Strength	Useful Strength	Identified Strength	Not Yet Identified Strength
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6+: Community Connection :

Centerpiece Strength	Useful Strength	Identified Strength	Not Yet Identified Strength
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Spiritual/Religious :

Centerpiece Strength	Useful Strength	Identified Strength	Not Yet Identified Strength
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6+: Involvement with Care :

Centerpiece Strength	Useful Strength	Identified Strength	Not Yet Identified Strength
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Educational Setting :

Centerpiece Strength	Useful Strength	Identified Strength	Not Yet Identified Strength
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16+: Vocational :

Centerpiece Strength	Useful Strength	Identified Strength	Not Yet Identified Strength
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0-21: Relationship Permanence :

Centerpiece Strength	Useful Strength	Identified Strength	Not Yet Identified Strength
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16+: Job History/Volunteering :

Centerpiece Strength	Useful Strength	Identified Strength	Not Yet Identified Strength
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2+: Resiliency :

Centerpiece Strength	Useful Strength	Identified Strength	Not Yet Identified Strength
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21+: Self-Care :

Centerpiece Strength	Useful Strength	Identified Strength	Not Yet Identified Strength
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6+: Optimism :

Centerpiece Strength	Useful Strength	Identified Strength	Not Yet Identified Strength
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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).

9. FAMILY INFORMATION

0 = No evidence/no reason to believe the item requires action.

1 = Watchful waiting, monitoring or preventive action.

2 = Need for Action. Some strategy is needed to address problems/needs.

3 = Immediate/intensive action. Safety concern; priority for intervention.

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).

involvement (client and family).

9b. Cultural Considerations
CULTURAL FACTORS

Language :

0123

Cultural Stress :

0123

Traditions and Rituals :

0123

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.).

10. NEEDS / RESOURCE ASSESSMENT

None (No additional needs / resources identified.)

Access to Food

Educational

Mentoring

Financial Assistance

Immigration Assistance

Clothing

Employment

Legal Assistance

Physical Health

Mental Health Service

Shelter

Other (specify) :

11 . DIAGNOSIS

Diagnostic Code	DSM - 5 Name	ICD - 10 Name	Diagnosis
	Schizophreniform Disorder		No

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.

13. ADDITIONAL CLIENT FUNCTIONING EVALUATIONS RECOMMENDED BY LPHA

No Additional evaluations

14 Section on Next Page

15. INDIVIDUAL TREATMENT PLAN

15a. Client and Family Vision Statement For Treatment

15b. Client and Family Service Preferences

Treatment Date :

14. SUMMARY OF PRIORITIZED CANS NEEDS AND STRENGTHS**Completed****14a. CANS Actionable Items to Consider for Treatment Planning**

Add Summary Of Prioritized CANS Needs And Strengths Section items

Section Name	Item Text	Item Option
Treatment Target Needs	sdffdsdfd	True

16. TREATMENT GOALS AND OBJECTIVE

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.

Start Date	Treatment Plan	Cans Items	Client Goal	Goal Status	Cans Treatment Plan Objective	Completed Date
11/27/2020	Discharge	dfffggf	goal1	Completed	obj1	11/27/2020 12:00:00 AM
11/27/2020	Discharge	dfffggf	goal1	Completed	obj2	11/27/2020 12:00:00 AM
11/27/2020	Discharge	dfffggf	goal2	Discontinue	obj1	
11/27/2020	Discharge	dfffggf	goal1	Continue	obj1	
11/27/2020	Discharge	dfffggf	goal1	Completed	obj1	11/27/2020 12:00:00 AM
11/27/2020	Discharge	dfffggf	goal1	Completed	obj2	11/27/2020 12:00:00 AM
11/27/2020	Discharge	dfffggf	goal2	Discontinue	obj1	
11/27/2020	Discharge	dfffggf	goal1	Continue	obj1	
11/27/2020	Discharge	dfffggf	gola4	Completed	obj	11/27/2020 12:00:00 AM
11/27/2020	Discharge	dfffggf	gola4	Completed	obj2	11/27/2020 12:00:00 AM
11/27/2020	Discharge	dfffggf	gola6	Discontinue	obj	
11/27/2020	Discharge	dfffggf	dffd	Continue	ddfd	
11/27/2020	Discharge	dfffggf	dffd	Continue	dffddf	
11/27/2020	Discharge	dfffggf	dffd	Continue	dffddffdfd	
11/27/2020	Discharge	dfffggf	dffd	Continue	fddffdfd	
11/27/2020	Discharge	dfffggf	goal1	Continue	obj1	
11/27/2020	Discharge	dfffggf	goal1	Continue	obj2	
11/27/2020	Discharge	dfffggf	goal2	Discontinue	obj1	
11/27/2020	Discharge	dfffggf	goal2	Discontinue	obj2	
11/27/2020	Discharge	dfffggf	goal1	Completed	obj1	11/27/2020 12:00:00 AM
11/27/2020	Discharge	dfffggf	goal1	Completed	obj2	11/27/2020 12:00:00 AM
11/27/2020	Discharge	dfffggf	goal1	Completed	obj3	11/27/2020 12:00:00 AM
11/27/2020	Discharge	dfffggf	goal1	Continue	obj3	
11/27/2020	Discharge	dfffggf	goal1			
11/27/2020	Discharge	dfffggf	goal1	Continue	obj1	
11/27/2020	Discharge	dfffggf	goal1	Continue	obj2	
11/27/2020	Discharge	dfffggf	goal2	Discontinue	obj1	
11/27/2020	Discharge	dfffggf	goal2	Discontinue	obj2	
11/27/2020	Discharge	dfffggf	goal1	Completed	obj1	11/27/2020 12:00:00 AM

11/27/2020	Discharge	dfffggf	goal1	Completed	obj2	11/27/2020 12:00:00 AM
11/27/2020	Discharge	dfffggf	goal1	Completed	obj3	11/27/2020 12:00:00 AM
11/27/2020	Discharge	dfffggf	goal1	Continue	obj3	
11/27/2020	Discharge	dfffggf	goal1			
11/27/2020	Discharge	dfffggf	dsfdfds	Continue	ffd	
11/27/2020	Discharge	dfffggf	dsfdfds	Continue	dsffd	
11/27/2020	Discharge	dfffggf	dsfdfds	Continue	dffd	
11/27/2020	Discharge	dfffggf	dsfdfds	Continue	ffd	
11/27/2020	Discharge	dfffggf	dsfdfds	Continue	dsffd	
11/27/2020	Discharge	dfffggf	dsfdfds	Continue	dffd	
11/27/2020	Discharge	dfffggf	fsdfd	Continue	fdf	
11/27/2020	Discharge	dfffggf	fsdfd	Continue	dfdf	

17. SERVICES / INTERVENTIONS

Objectives	Service Type	Mode	Place Of Service	Duration	Agency and Staff Responsible
No Records					

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)

Client (Print name) :

Date Time :

Signature :

PARENT/LEGAL GUARDIAN SIGNATURE

Parent/Legal Guardian (print name) :

Date Time :

Signature :

STAFF RESPONSIBLE FOR IM+CANS DEVELOPMENT, REVIEW, AND MODIFICATION SIGNATURE

MHP Electronic Signature :

MHP Staff Name :

MHP Staff Title :

MHP Signed Date and Time

QMHP Electronic Signature :

QMHP Staff Name :

QMHP Staff Title :

QMHP Signed Date and Time :

LPHA Electronic Signature :

LPHA Staff Name :

LPHA Staff Title :

LPHA Signed Date and Time :

18. GENERAL INFORMATION (HRA)

Staff Name :

Individual First Name :

Individual Last Name :

RIN :

Date Of Birth :

Gender :

Height : Ft In

Weight :

Primary Care
Doctor Name :

Date of Last Visit due
Physical Exam :

Date of Last Flu Shot :

19. MEDICATION (S)

List current and previous medications below, including over-the-counter medications. Attach additional pages as needed

Is the individual currently taking any psychotropic medications? Yes No

CANS Rating – Medication Compliance

If yes, does the individual regularly receive lab work? Yes No Not required Unknown

Individual regularly receive lab work Details.

Medication Name	Prescriber	Dosage	Date Started	Date Ended	Medication Issues
No Records					

20. HEALTH STATUS

a. Individual's self-report on general physical health

Excellent Good Fair Poor

c. How many servings of fruits and vegetables does the individual usually eat in a day?

0-1 2-3 More than 4

e. Does the individual use any form of tobacco?

Yes No

g. Has the individual ever fainted or passed out?

Yes No If yes, describe

i. Has the individual fallen in the past 12 months?

Yes No If yes, describe

b. How many snack foods or drinks (e.g., chips, cookies, candy, soda) does the individual usually consume in a day?

0-1 2-3 More than 4

d. Does the individual engage in physical activity?

Yes No If yes, how often ?

f. Does the individual drink alcohol?

Yes No If yes, how often and how much?

h. Does the individual have any allergies?

Yes No If yes, list

j. Does the individual want help to quit smoking?

Yes No

HEALTH CONCERNS:

Does the individual have any current health

Yes No If yes, describe

GENERAL ILLNESS:

Does the individual have a tendency to any illnesses

Yes No If yes, describe

BREATHING ISSUES:

Does the individual have any trouble breathing? Yes No (if NO, skip to next section)

a. What are the breathing issues related to? Check all that apply.

Does the individual have any trouble breathing? Physical activity Weather extremes Other

COGNITIVE ASSESSMENT : (skip if the individual is under age 50)

a. Has the individual ever had a significant head injury? Yes No If yes, when?

b. Does the individual have any difficulty remembering or recalling events? Yes No

c. Can the individual correctly tell you what year, month, and day it is? Yes No

BLOOD SUGAR / DIABETES:

a. Does the individual urinate more frequently than appears normal? Yes No

b. Does the individual seem to have an increased thirst, compared to others in the same age range? Yes No

c. Does the individual have any special dietary instructions related to his/her blood sugar? Yes No If yes, describe

d. Does the individual take any medication to control his/her blood sugar? Yes No

CHRONIC PAIN:

Does the individual experience chronic pain, or complain of pain frequently? Yes No (if NO, skip to next section)

a. Has the individual ever taken or been prescribed medication for pain? Yes No

If yes, indicate the type

Cannabis Opioids Other (list) :

b. Describe the location and intensity of the pain.

SEXUAL RISK BEHAVIORS:

Is the individual sexually active? Yes No (if NO, skip to next section)

a. Does the individual use any protection against sexually transmitted diseases/infections (STDs/STIs) when engaged in sexual activity? Yes Sometimes No

b. When was the individual last tested for STDs/STIs?

c. Has the individual ever been diagnosed with an STD/STI or HIV? Yes No

If yes, list the diagnosis and the age of occurrence

FEMALE REPRODUCTIVE HEALTH: (if the individual is a male, or if the female has not had her first period, skip to next section)

a. Does the individual see a women's health provider? Yes - Date of last visit No - referral needed

b. Is the individual experiencing any issues related to her menstrual cycle or menopause? Yes No

If yes, describe.

c. Is the individual currently or has the individual ever been pregnant? Yes -currently Yes - previously No

21. DEVELOPMENTAL HISTORY

Complete this section based on the individual's early childhood experiences.

a. Did the individual's mother receive the appropriate prenatal care? Yes No Unknown

b. Were there any complications during the mother's pregnancy? Yes (describe below) No Unknown

c. Was the individual's birth normal or premature? Normal Premature Unknown

d. Was the individual exposed to the mother's use of tobacco, alcohol, or street/prescription drugs during pregnancy?
Yes (describe below) No Unknown

e. Were there any unusual issues related to the mother's labor and delivery? Yes (describe below) No Unknown

f. What was the individual's birth weight?

g. When did the individual first
Crawl? Walk? Talk?

h. When did the individual begin toilet training?

i. Does the individual have a biological parent or sibling that has developmental or behavioral problems? Yes No Unknown

Supporting Information : Provide additional information on the individual's social/developmental history, including significant events in prenatal/birth/early childhood stages, enduring physical/medical conditions, and pervasive developmental or cognitive difficulties.

22. MEDICAL HISTORY

How many times has the individual been to the Emergency Room in the past 12 months?

0 1 time 2 times 3 times 4+ times

What was the reason for the ER visit(s)?

Has the individual ever been psychiatrically hospitalized?

Yes No s (If YES , please list below. Attach additional pages as needed)

List all additional hospitalizations the individual has experienced. Attach additional pages as needed.

N / A

Supporting Information: Describe any other significant medical problems, treatments, hospitalizations, and outcomes not addressed above .

23. GENERAL INFORMATION - CAREGIVER ADDENDUM

0 = No evidence/no reason to believe the item requires action.
1 = Watchful waiting, monitoring or preventive action.
2 = Need for Action. Some strategy is needed to address problems/needs.
3 = Immediate/intensive action. Safety concern; priority for intervention.

Client First :

Last Name :

RIN :

Staff Completing Form :

Date Completed :

23a. CAREGIVER RESOURCES & NEEDS

Caregiver Name :

Caregiver Relationship to Client :

Additional Primary Caregivers :

CAREGIVER RESOURCES & NEEDS

Supervision :

0 1 2 3

Safety :

0 1 2 3

Involvement with Care :

0 1 2 3

Family Stress :

0 1 2 3

Knowledge :

0 1 2 3

Marital/Partner Violence in the Home :

0 1 2 3

Social Resources :

0 1 2 3

Military Transitions :

0 1 2 3

Financial Resources :

0 1 2 3

Self-Care/Daily Living Skills :

0 1 2 3

Residential Stability :

0 1 2 3

Employment/Educational Functioning :

0 1 2 3

Medical/Physical :

0 1 2 3

Legal Involvement :

0 1 2 3

Mental Health :

0 1 2 3

0-21: Family Relationship to the System :

0 1 2 3

Substance Use :

0 1 2 3

0-21: Accessibility to Child Care :

0 1 2 3

Developmental :

0 1 2 3

0-21: Empathy with Children :

0 1 2 3

Organization :

0 1 2 3

Supporting Information : Provide additional information on caregiver strengths (some items rated 0 and 1) and needs (rated 2 and 3).

24. GENERAL INFORMATION - DCFS ADDENDUM

Youth's Name :

RIN :

Staff Completing Form :

Date Completed :

DCFS Involvement: Youth in care Intact Family Services Intensive Placement Stability Services (IPS)

25. [H2] SEXUALLY AGGRESSIVE BEHAVIOR SUB-MODULE - ADDITIONAL DCFS YOUTH ITEMS

0 = No evidence/no reason to believe the item requires action.
1 = Watchful waiting, monitoring or preventive action.
2 = Need for Action. Some strategy is needed to address problems/needs.
3 = Immediate/intensive action. Safety concern; priority for intervention.

This section is to be completed when the Sexually Problematic Behavior Module, Sexual Aggression item is rated 1, 2 or 3.

Temporal Consistency :

0 1 2 3

Severity of Sexual Abuse :

0 1 2 3

History of Sexually Abusive Behavior :

0 1 2 3

Prior Treatment :

0 1 2 3

Supplemental Information: Provide additional information regarding the youth's needs as it relates to his/her sexually aggressive behavior (items rated 2 and 3).

26. PARENT / GUARDIAN SAFETY CONCERNS

0 = No evidence/no reason to believe the item requires action.
1 = Watchful waiting, monitoring or preventive action.
2 = Need for Action. Some strategy is needed to address problems/needs.
3 = Immediate/intensive action. Safety concern; priority for intervention.

Discipline :

0 1 2 3

Frustration Tolerance :

0 1 2 3

Condition of the Home :

0 1 2 3

History of Maltreatment of Children :

0 1 2 3

Supplemental Information: Provide additional information regarding parent/guardian safety (items rated 2 and 3). The narrative can include relevant information from the Family Information section (IM+CANS, p. 7).

27. PARENT / GUARDIAN WELLBEING CONCERNS

0 = No evidence/no reason to believe the item requires action.
1 = Watchful waiting, monitoring or preventive action.
2 = Need for Action. Some strategy is needed to address problems/needs.
3 = Immediate/intensive action. Safety concern; priority for intervention.

Parent/Guardian Traumatic Reactions

0 1 2 3

Independent Living Skills

0 1 2 3

Parent/Guardian Understanding of Impact of Relationship/
Contact with Caseworker Own Behavior on Children

0 1 2 3

Parent/Guardian Understanding of Own Behavior on Children

0 1 2 3

Relationship/Contact with Caseworker Responsibility
in Maltreatment

0 1 2 3

Effective Parenting Approaches

0 1 2 3

Relationship with Abuser(s)

0 1 2 3

Supplemental Information : Provide additional information regarding parent/guardian resilience (items rated 2 and 3). The narrative can include relevant information from the Family Information section (IM+CANS, p. 7).

28. PARENT / GUARDIAN PERMANENCE CONCERNS

0 = No evidence/no reason to believe the item requires action.
1 = Watchful waiting, monitoring or preventive action.
2 = Need for Action. Some strategy is needed to address problems/needs.
3 = Immediate/intensive action. Safety concern; priority for intervention.

Social and Family Connections

0 1 2 3

Involvement in Personal Treatment

0 1 2 3

Parent/Guardian Participation in Visitation

0 1 2 3

Commitment to Reunification

0 1 2 3

Supplemental Information : Provide additional information regarding positive family, community, and social connections; and commitment to permanency plan goal (items rated 2 and 3).

29. SUBSTITUTE CAREGIVER COMMITMENT TO PERMANENCE

0 = No evidence/no reason to believe the item requires action.
1 = Watchful waiting, monitoring or preventive action.
2 = Need for Action. Some strategy is needed to address problems/needs.
3 = Immediate/intensive action. Safety concern; priority for intervention.

N / A -Youth does not have a substitute caregiver

Collaboration with Other Parents/Caregivers

0 1 2 3

Inclusion of the Youth in the Foster Family

0 1 2 3

Subst. Caregiver Support for Perm. Plan Goal

0 1 2 3

Supplemental Information : Provide additional information regarding the substitute caregiver's commitment to the permanency plan goal(items rated 2 and 3). The narrative can include relevant information from the Caregiver Needs and Strengths Addendum.

30. INTACT FAMILY SERVICES MODULE

0 = No evidence/no reason to believe the item requires action.
1 = Watchful waiting, monitoring or preventive action.
2 = Need for Action. Some strategy is needed to address problems/needs.
2 = Need for Action. Some strategy is needed to address problems/needs.

N / A - youth is not enrolled in intact family services

Parental/Secondary Caregiver Collaboration :

0 1 2 3

Family Role Appropriateness :

0 1 2 3

Family Conflict :

0 1 2 3

Home Maintenance :

0 1 2 3

Family Communication :

0 1 2 3

Supplemental Information : Provide additional information regarding the family system (items rated 2 and 3). The narrative can include relevant information from the Family Information section (IM+CANS, p. 7).

31. INTENSIVE PLACEMENT STABILIZATION SERVICES (IPS) MODULE

0 = No evidence/no reason to believe the item requires action.

1 = Watchful waiting, monitoring or preventive action.

2 = Need for Action. Some strategy is needed to address problems/needs.

3 = Immediate/intensive action. Safety concern; priority for intervention.

N / A - youth is not enrolled in IPS

Years in Care :

0 1 2 3

Knowledge of Youth's Development and Needs :

0 1 2 3

Placement History :

0 1 2 3

Discipline :

0 1 2 3

Substitute Caregiver Management of Emotions :

0 1 2 3

Supplemental Information : Provide additional information regarding the youth and substitute caregiver involved with the IPS program (items rated 2 and 3). The narrative can include relevant information from the Caregiver Needs and Strengths Addendum.