Case Management Assessment Update - Adult Version

This form has been designed to reduce provider agency risks and to save time. It provides a standard and efficient format for updating assessment information, re-admitting the Individual served (according to agency policy and procedures), and/or updating the clinical formulation and treatment recommendations. This new/additional information, which is often not easily identifiable in progress notes, creates audit risks for provider agencies. It must be clear to auditors how assessed needs, treatment recommendations and treatment are linked, especially when the information in the diagnostic assessment is outdated.

This form does not replace initial evaluations or assessments.

It is recommended that this form be kept in date order in the assessment portion of the Individual's record. In all cases, provider agencies should determine whether the new/additional information contained in this form requires an updated Individualized Action Plan (IAP) to be completed.

This form can be used whenever the provider believes that updated information (as described above) should be included in the medical record. Some organizations may want to routinely require updates on an annual basis, or when the Individual returns to care within a fairly short time period, or when the Individual changes level of care. Completion of an Adult case Management Assessment Update form does not necessarily assume billing of a diagnostic assessment service. For example, data obtained during a Case Management session that constitutes important new assessment information can be recorded on the Assessment Update while the service itself would be documented and billed as a Case Management session.

Data Field	Identifying Information
Organization and Program Name	Record the names of the Organization and the Program if applicable
Individual's Name	Record the first name, last name, and middle initial of the Individual being served. Order of name is at agency discretion.
Record #	Record your agency's established Record number for the Individual.
Date of Birth	Record the date of birth of the Individual. **(e.g. MM/DD/YYYY)**
Data Field	**Reason for Update**
Update of New Information, Re-Admission, Periodic Update	Check the appropriate box to indicate whether the Update is: • To Update New information • A Re-Admission Update for an individual who left services and has returned to services within a relatively short amount of time (the specific time frame/criteria for use of this form will be left up to each individual agency and their respective policies and procedures). • A Periodic Update as determined by agency policy/program regulations. Also, indicate date of Admission. Date of the last Assessment –Record the date of the last Assessment that was completed and is contained in the medical record.
Data Field	**Adult Case Management Assessment Sections**
Adult Case Management Assessment Sections	Check all applicable boxes next to the section(s) of the Assessment being updated. Use the corresponding number to indicate which section(s) is being updated (e.g. if one was updating substance abuse information, he/she would write #9 in the narrative section below and provide information). Updates may require an IAP Revision or a new IAP if there are changes to treatment including goals, objectives, services, and interventions offered.

Data Field	Update Narrative
Update Narrative	Provide a narrative explanation for each box selected in the section above. Indicate number which corresponds to each section being updated.

Data Field	**Individual Served/Family/Guardian Expression of Service Preferences**
Service Preferences	It is important that the clinician engage in a meaningful recovery focused dialogue with the Individual (and/or primary support Individual) which allows the Individual (and/or primary support Individual) to express his/her desired treatment, support preferences and priorities. Record the prioritized service preferences for the full range of behavioral health and community-based rehabilitative services, and environmental support services available, as identified by the Individual (and others involved with the Individual) based on the areas covered in the Assessed Needs.
	Include the Individual's preferences to develop or have available additional natural and community supports, as a part of his/her Recovery Process. If applicable to the Individual, discuss peer support, family education, other support, housing, transportation, social opportunities, and community involvement. Identify available resources. Discuss the Individual's preferences for activities focused on reducing prejudice and discrimination against him/her and/or increasing his/her power and control over his/her life and future.

Data Field	**Service Recommendations**
Service Recommendations / Assessed Needs	If, upon review of the most recent Adult Comprehensive Assessment and the information from this update there are no additional recommendations or assessed needs, check the box **No Additional Recommendations Clinically Indicated**.
	If there are additional Treatment Recommendations/Assessed Needs, the clinician, Individual served and others involved with the Individual, including family as appropriate, should collaborate to identify and prioritize needs. These identified needs should be considered as the basis for subsequent treatment goals and/or objectives and all should be geared to improving the functioning of the Individual or reducing his or her signs and symptoms.
	See Instructions for Adult Case Management Assessment for examples of Assessed Needs.

Data Field	**Individual Declined/Deferred/Referred**
Individual Declined/Deferred/Referred Out Rationale(s)	Describe reasoning behind worker's decisions to defer or refer out work on any assessed needs. Also provide reasoning behind decisions by the Individual served to decline a recommendation at this time.

Data Field	**Level of Care/ Indicated Services Recommendations**
Level of Care/ Indicated Services Recommendations	Identify the services that the individual is in need of, as identified in the assessment.

Data Field	**Individual Served/Guardian Family Response to Recommendations**
Individual Served/Guardian Family Response to Recommendations	Describe the individual's/family's response to the treatment recommendations.

Data Field	**Treatment Planning Updates**
Change In IAP Required	If the newly assessed therapeutic needs can be supported by the Goals, Objectives, Interventions, services, frequency, duration, and responsible provider(s) in the current IAP, then an IAP Revision is not required. If the assessed treatment needs cannot be supported by the current IAP, then a change in the IAP is required (revision or completion of new IAP). Please indicate the change by completing the appropriate form.

Data Field	Signatures
Individual Served Signature	Signature of the individual served (optional).
Provider – Print Name/Credential, Signature, and Date	Legibly print name, credential(s) and signature of individual completing the Assessment Update. Record the date of signature.
Supervisor – Print Name/Credential, Signature, and Date (if needed)	Legibly print name, credential(s) and signature of the Supervisor reviewing the Assessment Update and record the date of signature. (if needed)
Other – Print Name/Credential, Signature, and Date	Legibly print name, credential(s) and signature of individual reviewing the Assessment Update and record the date of signature. (if needed)