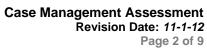








Organization Name:			Program Name:	Date:					
Individual's Name (Fil	ne (First MI Last): Record #: DOB:								
Date of Referral:									
	Reason for Referral and Chief Complaint/Presenting Problem								
Reason for Referral and	Reason for Referral and Chief Complaint/presenting problem-priority and/or emergency issues in individual's own words:								
Family/Guardian description of problem (if relevant):									
History of Present Ps	History of Present Psychiatric Illness (Describe course of presenting stressors/symptoms/concerns):								
Past Psychiatric History	ory (Previous episod	des of current sy	mptoms and any o	ther past psychiatric o	concerns):				
Does individual report pro	Substance Use/Addictive Behavior Screen Does individual report problems (historical or current) with any of the following? Ullegal drug Prescription drug Non-prescription (OTC) Alcohol Gambling Tobacco None Reported								
	A		Treatment Histor nent Service Hist						
	Treatment Service	ces History With	nin the Past 5 yea	rs 🗌 None Reporte	d				
Type of Services	Dates of Service	Rea	ason	Name of Provider/Agen	cy: Completed				
	1				□ No □ Yes				
	1				☐ No ☐ Yes				
	1				☐ No ☐ Yes				
	1				☐ No ☐ Yes				
	1				☐ No ☐ Yes				
	1				☐ No ☐ Yes				
	1				□ No □ Yes				
Comment further if additional episodes, as indicated: What was helpful with past treatment? What was not helpful? Additional Comments:									

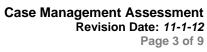








Organization Name:	Program Name:	Date:						
Individual's Name (First MI Last):	Record #:	DOB:						
Past and Current Social and Developmental Status: Developmental History (Include individual and family history, motor development and functioning, sensory, speech, hearing and language problems, previous diagnosis of developmental disability and any eligibility for Office of Persons with Developmental Disabilities (OPWDD) services):								
	Sexual History	inchia Dinana Annones						
Sexual History/Concerns (Include sexual orientation and o as indicated): ☐ NA – Based upon the Individual's age and need		icadie Disease Assessment						
Vocation	/Education/Employment							
Highest Grade Completed No formal education □ Fre-K □ Gth □ General Equivalency Diploma □ Vocational Cert w/o Diploma □ Vocational Cert w/o Diploma/GED □ 1st □ 8th □ Vocational Cert w/ Diploma/GED □ 2nd □ 19th □ Some College – No degree □ 10th □ Associates Degree □ 11th □ Bachelors Degree □ 12th, no diploma □ Graduate Degree								
Employment Status (Select First that applies) ☐ Competitive and integrated employment ☐ Other Employment ☐ Non-paid work position (volunteer) ☐ Unemployed and looking for work ☐ Not in Labor Force: unemployed but not looking for work, retired, homemaker, student, incarcerated or psychiatric inpatient								
Emplo	yment History 🗆 NA							
Type of Job	How Long Reas	on for Leaving						
_	Months / Years							
_	Months / Years							
	Months / Years							
_	Months / Years							
Approximate Literacy Level (Required for CARF-see Manual	ual) and impact on treatment, if any:							
Chil	dren and Adolescents							
Name of School:	Current Grade:							
Regular Education Classroom (No Special Services):	lo Yes - If no, check all that apply below.							
Educational Classification								
□ Deafness □ Orthop □ Deaf-Blindness □ Other I □ Emotional Disturbance □ Speech □ Hearing Impairment □ Traum	e disabilities Additional Information edic Impairment Health Impairment or language Impairment atic Brain Injury Impairment Gifted Additional Information Current 504 Plant Current 604 Plant							

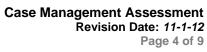








Organization Name:	Program Name:	Date:					
Individual's Name (First MI Last):	Record #:	DOB:					
Comments on Past and Current Academic Functioning (include grades, learning ability, learning style and any other relevant indicators):							
Test or Other Evaluation Results (IQ; achievement; develop	mental; PT/OT; etc.) 🗌 No Test Res	sults Reported					
Attendance: Not a Problem							
Previous Grade Retentions: Denied							
Suspensions/Expulsions: Denied							
Additional Barriers to Learning:							
Peer Relationship/Social Functioning:							
Vocation/Education/Employment Sci	r een/Summary (For Children/A	dolescents and Adults)					
Does the individual want help with or desire further discus strengths, weaknesses and aspirations (required for COA)		y area below, comment on history,					
Vocational No Yes - Comment:							
Educational No Yes - Comment:							
Employment No Yes - Comment:							
Military Service Screen							
Has the individual ever served in the military? No Yes	If yes, Comment:						
If yes, is the individual currently experiencing: Physical health concerns as a result of military experienced chronic pain? Concerns of possible infectious agents, toxins, or race Psychological Issues related to military service (Flas	☐ Frequent nausea, stomach updiological exposure?	oset, and/or deliriums?					
☐ Individual has concerns that seeking help may impact	his/her career.						
Comments:							
Further assessment with the Military Service Assessment	can be done <i>at any point during</i> c	are.					
Is there someone in the family, or a significant other, in the mill If yes, further assessment with the Military Service Assess	-						

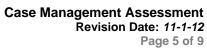








Organization Name:	Program Name:	Date:							
Individual's Name (First MI Last):	Record #:	DOB:							
LEGAL INVOLVEMENT HISTORY None Reported									
Does the individual have a history of, or current, involvement with the legal system (i.e., legal charges, AOT, Specialized Courts-Drug, Mental Health, Family, Arrests, Incarceration, etc.)? No Yes Is there a family history of, or current involvement with CPS? No Yes / APS? No Yes If yes to either of the above, complete and attach the Legal Involvement and History Addendum.									
	Legal Status								
Is there a Special Needs Trust other than parent? No Ye	Does Individual Served have a Legal Guardian, Rep Payee or Conservatorship? No Yes Is there a Special Needs Trust other than parent? No Yes If yes to either question above, complete and attach the Legal Status Addendum								
Is there a need for a Legal Guardian, Rep Payee, Conservators If Yes, explain:	hip or Special Needs trust?								
Does the individual have any advance directives? ☐ No ☐ Y If Yes, what type? ☐ DNR ☐ Health Care Proxy ☐ Living W	/ill Psychiatric Advance Directive								
	ence Personal Information Form)								
Household composition and any housing needs:	Household composition and any housing needs:								
Family Histo	ory and Relationships								
Comment on family/significant other relationships as applicable (Describe past and current relationships with family/significant others): Family History of Relevant Health (including Developmental Disabilities), Mental Health, and Addiction concerns: Custody Issues: NA OR: Describe custody arrangement/parenting plan as it relates to individual/comments:									
1	Гrauma History								
Does individual report a history, or current experience, of:									
Select all that are reported: Physical Abuse/Neglect									
Provide Relevant Details and Current Clinical Impact:									

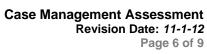








Organization Name:	Program Name:		Date:					
Individual's Name (First MI Last):	Record #:		DOB:					
Social/Leisure Supports/Concerns								
Friendships/Social/Pets/Peer Support Relationships:								
Meaningful Activities (Community Involvement, Volunteer Act	ivities. Leisure/Recreation	. Other Interests):						
	•	,						
Community Supports/Self Help Groups (AA, NA, NAMI, Dou	ble Trouble, Peer Support	, Meals-on-Wheels, etc	s.):					
Religion/Spirituality (Discuss protective and/or risk aspects):								
Cultural/Ethnic Information (Discuss protective or risk aspect	s):							
Functi	onal Assessment							
Comment on daily living skills and ability for self care (incl	uding financial needs):							
, ,	,							
Other functional impairments:								
Physic	cal Health History							
 □ Refer to Brief Medical Screening Form (includes particular of the property) □ Additional Comments, if indicated: 	•	tion information) date	ed:					
Suicide	and Violence Risk							
Suicide and Self	-Harm Screen/Assess	ment						
Source	es of Information							
☐ Columbia-Suicide Severity Rating Scale (C-SSRS)		☐ Clinical Interview	☐ Clinical records					
Other approach or evidence based tool (i.e. Chronological Assessr (CASE) Approach	ment of Suicide Events	☐ Collateral sources						
Suicidal ideation (history/current): No Yes – If Yes, provide details:								
Suicidal planning (history/current): No Yes - If Yes, prov	ride details:							
History of suicidal behaviors? ☐ No ☐ Yes - If Yes, provide details:								
History of self-injurious behavior (i.e. cutting, burning)? ☐ No │	Yes - If Yes, specify an Yes - If Yes - If Yes, specify an Yes - If Ye	a note safety managen	nent plan below:					

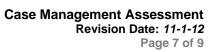








Organization Name:	Progran	n Name:	Date:					
Individual's Name (First MI Last):		Record #:	DOB:					
Is there evidence of suicide risk? No Yes – If Yes:								
Does the individual have access to lethal means/weapons? No Yes - If Yes, provide details:								
Describe discussion with individual/family to secure access to le	lethal mean	s/weapons.						
Identify and discuss impact of significant risk and protective/mit	itigating fact	ors:						
Safety Management Plan: Describe in detail how elements of r behavior:	risk will be r	managed, including any risk for non-s	uicidal self-injurious					
	Screen/A	ssessment						
Sources of Information - □ Evidenced-based screening/assessment tool(s)		☐ Clinical Interview	☐ Clinical records					
- If Yes, specify:		☐ Collateral sources	Cillical records					
Recent thought/intention or actual plan to hurt others? No	☐ Yes - If Y	es, provide details:						
History of threatening/attempting or actually hurting others?	No □ Yes	s - If Yes, provide details:						
Current and/or recent thoughts or behaviors that others might in	interpret as	threatening? No Yes - If Yes,	provide details:					
Other areas of concern including those from previous sections?	? □ No □	Yes - If Yes, note below as relevant	to risk factors.					
Is there evidence of violence risk? ☐ No ☐ Yes - If Yes:								
Does the individual have access to lethal means/weapons?] No ☐ Ye	s – If Yes, provide details:						
Describe discussion with individual/family to secure access to le	lethal mean	s/weapons.						
Identify and discuss impact of significant risk and protective/mit	itigating fact	ors:						
Safety Management Plan: Describe in detail how elements of risk will be managed and/or how continued assessment will be conducted:								
Life Goals, Strengths, Abilities, and Barriers								
Life Goals:								
Strengths (skills, talents, interests, protective factors):								
Barriers (environmental and personal):								
Past and Present Successes in Achieving Desired Goals:								

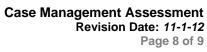








Other of Montes Halles Control of Lives,										
Organiza	tion Name:		F	Program Nan	ne:	Date:				
Individua	l's Name (F	irst MI Last):		Rece	ord #:	DOB:				
	Service Preferences: describe individual/family/guardian/significant other perception of needs and preferences for health care and behavioral health services, including family participation in care and environmental supports (self-help, advocacy and empowerment activities):									
Summary and Functional Eligibility										
Summary: What are the need areas and determination of the recipient's functional eligibility for services? (discuss the factors that led to the needs, and the skills and resources needed to address them. Comment on desire and motivation to learn, and ability/capacity to respond to services. Base summary on full Assessment which includes Referral Information, Personal Information Form and additional assessments/addendums completed (i.e. Brief Medical Screening; Communicable Disease; Substance Abuse; Legal, etc.).										
			Diagnosis: ☐ DS From Referral Infor		☐ ICD Codes /Date:					
Check Primary	Axis	Code		Naı	rative Description					
	Axis I									
	Axis II									
	Axis III									
		□ No □	ir Yes, describe:							
		□ No □	if Yes, describe:		ronment:					
		□ No □	if Yes, describe:							
		□ No □	ii res, describe.	ems:						
	Axis IV	□ No □`	ir Yes, describe.							
		□ No □	ii Yes, describe.							
		□ No □	ir Yes, describe.							
		□ No □	ir Yes, describe:							
		□ No □	Yes Other psychosocial If Yes, describe:	and environme	ental problems:					
	Axis V Current GAF: Highest GAF in Past Year (if known):									









Organization Name:	Program Name:	Date:				
Individual's Name (First MI Last):	Record #:		DOB:			
Further Evaluations Needed:	_					
□ None Indicated □ Psychiatric □ Psychologic □ Employment □ Visual □ Auditory	cal ☐ Neurological ☐ Medical ☐ Nutritional ☐ Other:		Educat	ional		
☐ Employment ☐ Visual ☐ Additory			A -Active	. IFD -Inc	lividual o	r
Prioritized Assessed N	eeds:	Family/Guardian Declined, D -Deferred, N/A -Not Applicable, R -Referred Out				
		Α	IFD*	D*	NA*	R*
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
*Individual Declined/Deferred/Referred Out-Rational						List
rationale(s) for why Need Area(s) is/are Deferred/Refer. 1.	red Out/NA; Offer time frame for defe	rment k	below).	∐ No	ne	
2.						
3.						
4.						
5. 6.						
7.						
8.						
Individual Served/Guardian/Family Response to Recomm	endations (if family did not participate ex	olain wh	ny):			





Case Management Assessment Revision Date: 11-1-12 Page 9 of 9

Organization Name:				Program Name:				1	Date:		
Individua	al's Name (Firs	st MI Last):				R	ecord #	:	I	DOB:	
Individual Served Signature (Optional):										Date:	
Guardian Signature (Optional):								Date:			
Completed By - Print Name/Credentials: Staff Signature:						Date:					
Team Leader/Clinical Supervisor - Print Name/Credentials (if needed):					Team Leader/Clinical Supervisor Signature (if needed):						Date:
For progr	For programs using this as a billable note, fill out Billing Strip below.										
Date of Service	Staff Identifier	Loc. Code	Service Code	Mod 1	Mod Mod Mod Start Stop 2 3 4 Time Time					Duration in Minutes	