Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

☐ **Assessment/Referral Information Received Dated**:

Reason for Referral and Chief Complaint/Presenting Problem

Reason for Referral and Chief Complaint/presenting problem-priority and/or emergency issues in individual's own words):

Family/Guardian/Other description of problem/need (if relevant):

History of Present Psychiatric Illness (Describe course of presenting stressors/symptoms/concerns):

Past Psychiatric History (Previous episodes of current symptoms and any other past psychiatric concerns)

Substance Use/Addictive Behavior Screen

Does individual report problems (historical or current) with any of the following?

☐ Illegal drug ☐ Prescription drug ☐ Non-prescription (OTC) ☐ Alcohol ☐ Gambling ☐ Tobacco ☐ None Reported

If yes to any complete Substance Use/Addictive Behavior Assessment.

Mental Health Treatment History ☐
Addiction Treatment Service History ☐

Treatment Services History Within the Past 5 years ☐ **None Reported**

Type of Services	Dates of Service	Reason	Name of Provider/Agency:	Completed
	/			☐ No ☐ Yes
	/			☐ No ☐ Yes
	/			☐ No ☐ Yes
	/			☐ No ☐ Yes
	/			☐ No ☐ Yes
	/			☐ No ☐ Yes
	/			☐ No ☐ Yes

Comment further if additional episodes, as indicated:

What was helpful with past treatment?

What was not helpful?

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):

Symptom Management Plan

☐ **Existing Relapse / Safety Plan Attached, No Update Required Or Complete:**

What are the individual's early warning signs/triggers that things are too stressful, deteriorating, or not going well that could be a sign of relapse?

What actions can the individual take and what supports will the individual need to manage stress, stay well, and remain focused on goals?

Sexual History

Sexual History/Concerns (Include sexual orientation and other relevant information; OMH complete Communicable Disease Assessment as indicated**):** ☐ NA – Based upon the Individual's age and needs

Vocation/Education/Employment

Highest Grade Completed

☐*No formal education*	☐*5th*	☐*High School Diploma*
☐*Pre-K*	☐*6th*	☐*General Equivalency Diploma*
☐*Kindergarten*	☐*7th*	☐*Vocational Cert w/o Diploma/GED*
☐*1st*	☐*8th*	☐*Vocational Cert w/ Diploma/GED*
☐*2nd*	☐*9th*	☐*Some College – No degree*
☐*3rd*	☐*10th*	☐*Associates Degree*
☐*4th*	☐*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

Employment History ☐ NA

Type of Job	How Long	Reason for Leaving
	_____Months / _____ Years	
	_____Months / _____ Years	
	_____Months / _____ Years	
	_____Months / _____ Years	

Approximate Literacy Level (Required for CARF-see Manual) and impact on involvement in this residential setting, if any:

Children and Adolescents

Name of School:	***Current Grade:***
Regular Education Classroom (*No Special Services****):*** ☐ *No* ☐ *Yes - If no, check all that apply below.*	
Educational Classification	

Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

☐ *Autism*
☐ *Deafness*
☐ *Deaf-Blindness*
☐ *Emotional Disturbance*
☐ *Hearing Impairment*
☐ *Intellectual disability*
☐ *Learning disability*
☐ *Multiple disabilities*
☐ *Orthopedic Impairment*
☐ *Other Health Impairment*
☐ *Speech or language Impairment*
☐ *Traumatic Brain Injury*
☐ *Visual Impairment*

Additional Information, if indicated:
Current IEP: ☐ *No* ☐ *Yes*
Current 504 Plan: ☐ *No* ☐ *Yes*

☐ *Home Schooled*
☐ *Gifted*

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; developmental; PT/OT; etc.)* ☐ *No Test Results Reported -*

Attendance: ☐ *Not a Problem -*

Previous Grade Retentions: ☐ *Denied* ***-***

Suspensions/Expulsions: ☐ *Denied* ***-***

Additional Barriers to Learning:

Peer Relationship/Social Functioning:

Vocation/Education/Employment Screen/Summary (For Children/Adolescents and Adults)

Does the individual want help with or desire further discussion of the following? If yes to any area below, comment on history, strengths, weaknesses and aspirations (required for COA):

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, does the individual have any concerns related to military service that will impact involvement in a residential setting?
☐ No ☐ Yes, if yes, Comment:

Further assessment with the Military Service Assessment can be done *at any point while in this residential setting.*

Is there someone in the family, or a significant other, in the military? ☐ No ☐ Yes, if yes, Comment:

If yes, further assessment with the Military Service Assessment for Significant Others can be done *at any point while in this residential setting.*

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

Does Individual Served have a Legal Guardian, Rep Payee or Conservatorship? ☐ No ☐ Yes
If Child, 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, Conservatorship or Special Needs trust? ☐ No ☐ Yes
If yes, explain:

Does the individual have any advance directives? ☐ No ☐ Yes
If yes, what type? ☐ DNR ☐ Health Care Proxy ☐ Living Will ☐ Psychiatric Advance Directive

Living Situation (Reference Personal Information Form)

Household composition and any housing needs:

Describe past living situations and experiences including community residence/apartment program:

Prospective Housing Situation

What does the individual think about living in this residential setting?

What are the strengths (skills/personal resources that can be used in this residential setting)?

Are there any areas which might be challenging (i.e., expectations, responsibilities, staff supervision, living with someone who smokes, visiting/smoking/pet policies?)

Is the individual willing to share a bedroom? Ever shared a bedroom before?

Family History 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:

Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

Trauma History

Does individual report a history, or current experience, of:

Select all that are reported:

☐ Physical Abuse/Neglect ☐ Elder Abuse ☐ Community Violence ☐ Verbal/Emotional Abuse ☐ Sexual Abuse/Molestation
☐ Immigration Trauma ☐ Witness to Violence ☐ Domestic Violence
☐ Other:
☐ None Reported

Provide Relevant Details and Current Impact upon Residential Services:

Social/Leisure Supports/Concerns

Friendships/Social/Pets/Peer Support Relationships:

Meaningful Activities (Community Involvement, Volunteer Activities, Leisure/Recreation, Other Interests):

Community Supports/Self Help Groups (AA, NA, NAMI, Double Trouble, Peer Support, Meals-on-Wheels, etc.):

Religion/Spirituality (Discuss protective and/or risk aspects/special needs related to residential living):

Cultural/Ethnic Information (Discuss protective or risk aspects/special needs related to residential living):

Assessment of daily living skills and ability for self care:

Physical Health History

Allergies: ☐No Known Allergies
Food: **Medication**: **Environmental**: **Other**:

Doctor's Name	**Address**	**Phone Number**	**Date of Last Exam**
Dentist's Name	**Address**	**Phone Number**	**Date of Last Exam**

Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

Has a Doctor EVER told you that you had any of the following conditions?

Condition	**Check One**		**Currently Under a Doctor's Care**	**Comment**
	Now	Past		
Alzheimer's Disease or Dementia	☐	☐		
Blood Sugar-High	☐	☐		
Blood Pressure (High)	☐	☐		
Cancer	☐	☐		
Deafness or other hearing impairment	☐	☐		
Diabetes	☐	☐		
Endocrine Condition (High or Low thyroid, Pituitary or Adrenal Disease)	☐	☐		
Epilepsy/Seizures	☐	☐		
Heart Attack	☐	☐		
Hyperlipidemia (High blood fat/Cholesterol and/or Trigycerides)	☐	☐		
Joint and connective tissue disease (Lupus, Rheumatoid arthritis, Osteoporosis, Osteoarthritis	☐	☐		
Kidney Disease	☐	☐		
Liver Disease ((Cirrhosis), Hepatitis A/B/C))	☐	☐		
Mobility Impairment	☐	☐		
Other Cardiac Condition	☐	☐		
Progressive neurological condition (Multiple Sclerosis (MS), Cerebral palsy, Amyotrophic Lateral Sclerosis (ALS))	☐	☐		
Pulmonary (Emphysema (Chronic Pulmonary Disease (COPD), Asthma)	☐	☐		
Sexually Transmitted or other Communicable Disease (for example, Herpes, Human Immunodeficiency Virus (HIV), History of active tuberculosis*) - If Yes to any, complete Communicable Disease Risk Assessment	☐	☐		
Sight Impairment	☐	☐		
Speech Impairment	☐	☐		
Stroke	☐	☐		
Traumatic Brain Injury	☐	☐		
Weight (Obesity, Unexplained Gain or Loss)	☐	☐		
Other physical related health conditions	☐	☐		

Joint Commission Only

If Physical Examination was performed within 12 months prior to admission, have there been any changes in individual's physical health condition? ☐ No ☐ Yes – Describe:

If Yes, does this information prompt a new physical examination referral? ☐ No ☐ Yes - Describe any actions required**:**

Does the individual have any issues with self-preserving/evacuating during emergencies? ☐ No ☐ Yes, specify:

Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

CURRENT Medication Information ☐ None Reported

(Include all current medication-Psych/Non-Psych /Prescription/ OTC/ Herbal)

Medication	Reason for Taking	Dosage/Frequency and When taken (dates/length of time)	Side-effects	Helpful?	Prescriber
		-		☐ **No** ☐ **Yes**	
		-		☐ **No** ☐ **Yes**	
		-		☐ **No** ☐ **Yes**	
		-		☐ **No** ☐ **Yes**	
		-		☐ **No** ☐ **Yes**	
		-		☐ **No** ☐ **Yes**	
		-		☐ **No** ☐ **Yes**	
		-		☐ **No** ☐ **Yes**	
		-		☐ **No** ☐ **Yes**	
		-		☐ **No** ☐ **Yes**	

Suicide and Self-Harm Screen/Assessment

Sources of Information

☐ Columbia-Suicide Severity Rating Scale (C-SSRS)
☐ Clinical Interview
☐ Clinical records
☐ Other approach or evidence based tool (i.e. Chronological Assessment of Suicide Events (CASE) Approach – If yes, specify:
☐ Collateral sources

Suicidal ideation (history/current): ☐ No ☐ Yes – If Yes, provide details:

Suicidal planning (history/current): ☐ No ☐ Yes - If Yes, provide details:

History of suicidal behaviors? ☐ No ☐ Yes - If Yes, provide details:

History of self-injurious behavior (i.e. cutting, burning)? ☐ No ☐ Yes - If Yes, provide details and note safety management plan below:

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 lethal means/weapons.

Identify and discuss impact of significant risk and protective/mitigating factors:

Safety Management Plan: Describe in detail how elements of risk will be managed, including any risk for non-suicidal self-injurious behavior:

Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

Violence Screen/Assessment

Sources of Information -

☐ Evidenced-based screening/assessment tool(s) Approach – If yes, specify:
☐ Clinical Interview
☐ Collateral sources
☐ Clinical records

Recent thought/intention or actual plan to hurt others? ☐ No ☐ Yes - If Yes, provide details:

History of threatening/attempting or actually hurting others? ☐ No ☐ Yes - If Yes, provide details:

Current and/or recent thoughts or behaviors that others might 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 ☐ Yes – If Yes, provide details:

Describe discussion with individual/family to secure access to lethal means/weapons.

Identify and discuss impact of significant risk and protective/mitigating factors:

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:

Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

Formulation – Interpretative Summary

Interpretive Summary: What in your clinical judgment are the need areas, the factors that led to the needs, and the skills and resources needed to address them? Include the needs indicated by the family/caregiver. Base summary on Referral Information and full Assessment which includes Personal Information Form and additional assessments/addendums completed (i.e. Communicable Disease; Substance Abuse; Legal, etc.).

Diagnosis: ☐ DSM Codes ☐ ICD Codes
From Referral Information Record/Date:

Check Primary	Axis	Code	Narrative Description
☐	Axis I		
☐			
☐			
☐	Axis II		
☐			
	Axis III		
	Axis IV		
	Current GAF:		Highest GAF in Past Year (if known):

Prioritized Assessed Needs:	**A**-Active, **IFD**-Individual or Family/Guardian Declined, **D**-Deferred, **N/A**-Not Applicable, **R**-Referred Out				
	A	**IFD***	**D***	**NA***	**R***
1.	☐	☐	☐	☐	☐
2.	☐	☐	☐	☐	☐
3.	☐	☐	☐	☐	☐
4.	☐	☐	☐	☐	☐
5.	☐	☐	☐	☐	☐
6.	☐	☐	☐	☐	☐
7.	☐	☐	☐	☐	☐
8.	☐	☐	☐	☐	☐

Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

9.	☐	☐	☐	☐	☐

***Individual Declined/Deferred/Referred Out-Rationale(s)** *(Explain why the Individual Declined to work on Need Area; List rationale(s) for why Need Area(s) is/are Deferred/Referred Out/NA; Offer time frame for deferment below).* ☐ None

1.

2.

3.

4.

5.

6.

7.

8.

Result of Intake Assessment

☐ Individual Is Not Being Recommended for participation. Rationale for non-admission:

☐ Individual Is Being Recommended for Participation (complete section below)

Recommended residential setting:

Recommended services (check all that apply):

Adult Services

☐ Assertiveness/Self-Advocacy Training
☐ Community Integration Services/Resource Development
☐ Daily Living Skills Training
☐ Health Services
☐ Medication Management and Training
☐ Parenting Training
☐ Rehabilitation Counseling
☐ Skill Development Service
☐ Socialization
☐ Substance Abuse Services
☐ Symptom Management
☐ Other:

Children and Adolescent Services

☐ Behavior Support
☐ Case Management
☐ Counseling Services
☐ Daily Living Skills Training
☐ Educational-Vocational Support Services
☐ Family Support Services
☐ Health Services
☐ Independent Living Skills Training
☐ Medication Management and Training
☐ Medication Monitoring
☐ Respite
☐ Socialization
☐ Other:
☐ Other:

Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**
Additional Comments, if indicated:		
Individual Served/Guardian/Family Response to Recommendations (if family did not participate explain why):		

Individual Served Signature (if indicated):		**Date:**
Guardian's Signature (if indicated):		**Date:**
Completed By - Print Name/Credentials:	**Signature:**	**Date:**
Team Leader/Clinical Supervisor - Print Name/Credentials (if needed):	**Team Leader/Clinical Supervisor Signature** (if needed):	**Date:**