

**HFS**Illinois Department of
Healthcare and Family Services

- ☐ Initial
- ☐ Update
- ☐ Re-assessment

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

1. GENERAL INFORMATION					
Customer First and Last Name:		Chosen/Preferred Name:		Pronouns:	Date First Contact:
RIN:	Date of Birth:	Sex at Birth:	Gender Identity:	Phone Number:	Primary Language:
Address:		City:	State:	Zip Code:	County:
Interpreter <input type="checkbox"/> None required <input type="checkbox"/> TDD/TYY <input type="checkbox"/> Spoken Language: _____ Services: <input type="checkbox"/> American Sign Language <input type="checkbox"/> Other: _____				Ethnicity: <input type="checkbox"/> Hispanic or Latinx <input type="checkbox"/> Unknown <input type="checkbox"/> Non-Hispanic or Latinx	
Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Other: _____ <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Hawaiian Native/Other Pacific Islander <input type="checkbox"/> Multi-Race				Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Unknown	
Insurance Coverage:	Household Size:	Household Income:	Guardianship Status: <input type="checkbox"/> Own guardian <input type="checkbox"/> Youth in Care <input type="checkbox"/> Biological parent <input type="checkbox"/> Other court appointed <input type="checkbox"/> Adoptive parent <input type="checkbox"/> Other: _____		
Living Arrangement: <input type="checkbox"/> Private residence <input type="checkbox"/> Homeless/shelter <input type="checkbox"/> Jail/correctional facility <input type="checkbox"/> Foster home <input type="checkbox"/> State op. facility (MH/DD) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Supportive/assisted living <input type="checkbox"/> Residential/institution			Employment Status: <input type="checkbox"/> Self-employed <input type="checkbox"/> Military <input type="checkbox"/> Employed full-time <input type="checkbox"/> Unemployed <input type="checkbox"/> Homemaker <input type="checkbox"/> Employed part-time <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Unable to work		
Education Level: <input type="checkbox"/> Never attended <input type="checkbox"/> Grade 4-5 <input type="checkbox"/> H.S. diploma/GED <input type="checkbox"/> Trade/technical training <input type="checkbox"/> Master's/Doctoral degree (last completed) <input type="checkbox"/> Pre-K/Kindergarten <input type="checkbox"/> Grade 6-8 <input type="checkbox"/> Some college <input type="checkbox"/> Professional certificate <input type="checkbox"/> Unknown <input type="checkbox"/> Grade 1-3 <input type="checkbox"/> Grade 9-12 <input type="checkbox"/> Associate's degree <input type="checkbox"/> Bachelor's degree					
2. ESTABLISHED SUPPORTS					
Does the customer have one or more caregivers? <input type="checkbox"/> Yes (please complete the Caregiver Addendum) <input type="checkbox"/> No					
Caregiver or Significant Other Info.	First and Last Name:		Relationship to Client: <input type="checkbox"/> Parent <input type="checkbox"/> Legal guardian <input type="checkbox"/> Other caregiver <input type="checkbox"/> Significant Other		Phone Number:
	Address:		City:	State:	Zip Code:
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 <input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
Other Supports	Agency	Contact Name	Phone	Email	
Physician					
School/Daycare					
Counselor/Therapist					
Child Welfare Worker					
ISC/PAS Agent					
Probation Officer					
Other: _____					
Other: _____					
Other: _____					

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. 2 = Need for action. Some strategy is needed to address problem/need.
1 = Watchful waiting, monitoring, or preventive action. 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. Items with a letter in parentheses after them indicate the item triggers a module when scored a 1, 2, or 3. All modules can be found in the IM+CANS Modules Addendum.

3. TRAUMA EXPOSURE

No = Unknown, not currently disclosed, or no evidence of any trauma of this type

Yes = Customer has, or is suspected of having, at least one incident, multiple incidents, or chronic, ongoing experience of this type of trauma

POTENTIALLY TRAUMATIC EXPOSURES

Item	No	Yes	Item	No	Yes	Item	No	Yes
Sexual Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Natural or Manmade Disaster	<input type="checkbox"/>	<input type="checkbox"/>	Disruptions in Caregiving / Attachment Losses	<input type="checkbox"/>	<input type="checkbox"/>
Physical Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Witness to Family Violence	<input type="checkbox"/>	<input type="checkbox"/>	Parental Criminal Behavior	<input type="checkbox"/>	<input type="checkbox"/>
Neglect	<input type="checkbox"/>	<input type="checkbox"/>	Witness to Community/School Violence	<input type="checkbox"/>	<input type="checkbox"/>			
Emotional Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Victim/Witness to Criminal Activity	<input type="checkbox"/>	<input type="checkbox"/>			
Medical Trauma	<input type="checkbox"/>	<input type="checkbox"/>	War/Terrorism Affected	<input type="checkbox"/>	<input type="checkbox"/>			

Supporting Information: Provide additional information on the type of trauma experienced by the customer (items rated yes) and the age of occurrence. Other trauma exposures not captured by an item above may be documented here.

4. PRESENTING PROBLEM AND IMPACT ON FUNCTIONING

4a. Presenting Situation and Presenting Symptoms

BEHAVIORAL/EMOTIONAL NEEDS

Item	n/a	0	1	2	3	Item	n/a	0	1	2	3
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3+: Impulsivity/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3+: Anger Control/Frustration Tolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating Disturbance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Substance Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adjustment to Trauma [A]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Addictive Behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Atypical/Repetitive Behaviors [B]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Psychosis (Thought Disorder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0-5: Regulatory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Conduct/Antisocial Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0-5: Failure to Thrive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Mania	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3-18: Oppositional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16+: Interpersonal Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						21+: Somatization	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4b. Impact of Problems on Customer's Functioning

LIFE FUNCTIONING

Item	n/a	0	1	2	3	Item	n/a	0	1	2	3
Family Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0-5: Elimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Living Situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0-21: School/Preschool/Daycare [C]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Residential Stability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3+: Decision Making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Legal [K]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation/Play	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Sexual Development	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental/Intellectual [B]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12+: Intimate Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16+: Job Functioning/Employment [D]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical/Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16+: Parental/Caregiving Role [E]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Compliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16+: Independent Living Skills [F]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21+: Basic Activities of Daily Living	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1+: Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21+: Routines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0-5: Motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21+: Functional Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0-5: Sensory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21+: Hoarding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0-5: Persistence/Curiosity/Adaptability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21+: Loneliness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Supporting Information: Provide additional information regarding presenting situation and symptoms (items rated 2 or 3 from the Emotional/Behavioral domain and Module A). Information on the impact of the presenting situation on the customer's functioning (items rated 2 or 3 from the Life Functioning domain or Modules B-F) should also be included in the narrative.

5. SAFETY

5a. Risk Behaviors

Item	n/a	0	1	2	3	Item	n/a	0	1	2	3
Victimization/Exploitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Sexually Prob. Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0-5: Self-Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Sexual Aggression [I]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0-5: Prenatal Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Bullying Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0-5: Birth Weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Non-Suicidal Self-Inj. Beh. (Self-Mut.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0-21: Flight Risk/Runaway [G]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Other Self-Harm (Recklessness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3+: Suicide Risk [H]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Danger to Others [J]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3+: Intentional Misbehavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Fire Setting [K]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						6+: Delinquent/Criminal Behavior [L]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Supporting Information: Provide additional information regarding the customer's risk behaviors (items rated 2 or 3 from the Risk Behaviors Domain, including aggressive/violent behavior/danger to others (items rated 2 and 3), and the level of impairment (e.g., school suspension, crisis services, hospitalization).

5b. Factors in Current Environment

Identify the factors in the customer's current environment that may create threats to the customer's personal safety (e.g., gang involvement, domestic violence, active abuse, access to weapons).

6. PLACEMENT HISTORY

Describe previous and current out of home placements for the customer (e.g., shelters, foster care, group home, nursing home)

☐ Customer has not had any out of home placements.

7. PSYCHIATRIC INFORMATION

7a. General Mental Health History

Has the customer ever had a psychological evaluation? ☐ No ☐ Yes Date: _____ IQ: _____

Has the customer ever had a psychiatric evaluation? ☐ No ☐ Yes Date: _____

Prior Mental Health Treatment

Describe any prior mental health treatment the customer has received. Include the types of services received, when, where, with whom, and the reason for the treatment, including any prior diagnoses treated (if known).

7b. Mental Status**Observations**

Appearance: ☐ Neat ☐ Disheveled ☐ Inappropriate ☐ Bizarre ☐ Other:
 Speech: ☐ Normal ☐ Tangential ☐ Impoverished ☐ Pressured ☐ Other:
 Eye Contact: ☐ Normal ☐ Intense ☐ Avoidant ☐ Other:
 Motor Activity: ☐ Normal ☐ Restless ☐ Tics ☐ Slowed ☐ Other:
 Affect: ☐ Full ☐ Labile ☐ Angry ☐ Flat ☐ Constricted ☐ Other:

Mood

☐ Normal ☐ Depressed ☐ Euphoric ☐ Anxious ☐ Angry ☐ Irritable ☐ Other:

Cognition

Orientation Impairment: ☐ None ☐ Place ☐ Object ☐ Person ☐ Time
 Memory Impairment: ☐ None ☐ Short-term ☐ Long-term ☐ Other:
 Attention: ☐ Normal ☐ Distracted ☐ Other:

Thoughts and Perception

Hallucinations: ☐ None ☐ Auditory ☐ Visual ☐ Other:
 Suicidal: ☐ Yes ☐ No
 Homicidal: ☐ Yes ☐ No
 Delusions: ☐ None ☐ Grandiose ☐ Paranoid ☐ Religious ☐ Other:

Behavior

☐ Cooperative ☐ Guarded ☐ Hyperactive ☐ Agitated ☐ Paranoid ☐ Aggressive ☐ Bizarre
☐ Withdrawn ☐ Other:

Judgment

☐ Good ☐ Fair ☐ Poor

Insight

☐ Good ☐ Fair ☐ Poor

Supporting Information: Document clinical observations to support the customer's current mental status as noted above.

8. STRENGTHS

0 = Centerpiece Strength 1 = Useful Strength 2 = Identified Strength 3 = Not Yet Identified Strength

Item	n/a	0	1	2	3	Item	n/a	0	1	2	3
Family Strengths/Support	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Talents and Interests	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpersonal/Social Connectedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Cultural Identity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Natural Supports	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Community Connection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spiritual/Religious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Involvement with Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Educational Setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16+: Vocational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0-21: Relationship Permanence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16+: Job History/Volunteering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2+: Resiliency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21+: Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6+: Optimism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

Supporting Information: Provide additional information on the customer's useful strengths (items rated 0 and 1) – the aspects of the community and people in the customer's network that provide support, and traits of the customer they have used to achieve their goals.

9. FAMILY INFORMATION**9a. Relevant Family History**

Describe precipitating and other significant family life events leading to current situation (e.g., divorce, immigration, losses, moves, financial difficulties). Please include information not captured elsewhere in the IM+CANS related to: 1) family history of behavioral health challenges, 2) current court involvement (customer and family).

9b. Cultural Needs

Item	0	1	2	3	Item	0	1	2	3
Language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cultural Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traditions and Rituals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

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, level of acculturation/assimilation).

10. ICD-10 DIAGNOSIS

ICD-10 Code	ICD-10 Name	Preventive Diagnosis
_____	_____	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>

Additional Information: Use this space if there is any additional information that is helpful to document regarding the customer's diagnosis not captured elsewhere in the IM+CANS (e.g. rule out diagnoses, outputs of diagnostic assessments that helped inform the listed diagnosis).

11. MENTAL HEALTH ASSESSMENT SUMMARY

Summary analysis and conclusion regarding the medical necessity of services. Tie all key information about the customer's mental health needs and diagnosis here.

12. SUMMARY OF PRIORITIZED CANS NEEDS AND STRENGTHS**12a. CANS Actionable Items to Consider for Care Planning**

Background – Trauma Experiences		Background – Other Needs	
Item:	<input type="checkbox"/> Y <input type="checkbox"/> N	Item:	<input type="checkbox"/> 2 <input type="checkbox"/> 3
Item:	<input type="checkbox"/> Y <input type="checkbox"/> N	Item:	<input type="checkbox"/> 2 <input type="checkbox"/> 3
Item:	<input type="checkbox"/> Y <input type="checkbox"/> N	Item:	<input type="checkbox"/> 2 <input type="checkbox"/> 3
Treatment Target Needs		Anticipated Outcome Needs	
Item:	<input type="checkbox"/> 2 <input type="checkbox"/> 3	Item:	<input type="checkbox"/> 2 <input type="checkbox"/> 3
Item:	<input type="checkbox"/> 2 <input type="checkbox"/> 3	Item:	<input type="checkbox"/> 2 <input type="checkbox"/> 3
Item:	<input type="checkbox"/> 2 <input type="checkbox"/> 3	Item:	<input type="checkbox"/> 2 <input type="checkbox"/> 3
Item:	<input type="checkbox"/> 2 <input type="checkbox"/> 3	Item:	<input type="checkbox"/> 2 <input type="checkbox"/> 3
Item:	<input type="checkbox"/> 2 <input type="checkbox"/> 3	Item:	<input type="checkbox"/> 2 <input type="checkbox"/> 3
Centerpiece/Useful Strengths		Strengths to Build	
Item:	<input type="checkbox"/> 0 <input type="checkbox"/> 1	Item:	<input type="checkbox"/> 2 <input type="checkbox"/> 3
Item:	<input type="checkbox"/> 0 <input type="checkbox"/> 1	Item:	<input type="checkbox"/> 2 <input type="checkbox"/> 3
Item:	<input type="checkbox"/> 0 <input type="checkbox"/> 1	Item:	<input type="checkbox"/> 2 <input type="checkbox"/> 3
Item:	<input type="checkbox"/> 0 <input type="checkbox"/> 1	Item:	<input type="checkbox"/> 2 <input type="checkbox"/> 3
Caregiver Resources		Caregiver Needs	
Item:	<input type="checkbox"/> 0 <input type="checkbox"/> 1	Item:	<input type="checkbox"/> 2 <input type="checkbox"/> 3
Item:	<input type="checkbox"/> 0 <input type="checkbox"/> 1	Item:	<input type="checkbox"/> 2 <input type="checkbox"/> 3
Item:	<input type="checkbox"/> 0 <input type="checkbox"/> 1	Item:	<input type="checkbox"/> 2 <input type="checkbox"/> 3

13. INDIVIDUAL PLAN OF CARE**13a. Customer and Family Vision Statement**

What does the customer and family want their lives to look like after treatment?

13b. Customer and Family Service Preferences.

Document any preferences the customer and family have related to services (e.g., types of services, location, modalities, time of day, practitioner preferences).

13c. Customer and Family Centered Goals.

Goals should be stated in customer/family language and should relate back to prioritized CANS actionable items. Goals are specific, observable outcomes related to functioning that result from targeting symptoms and behaviors. For customers working with multiple behavioral health providers or in care coordination programs, this should include all treatment goals addressed across all treatment providers.

Goal #1:

CANS Item(s):

Goal 1 Status: ☐ New ☒ Continue ☐ Discontinue ☐ Completed**Goal #2:**

CANS Item(s):

Goal 2 Status: ☐ New ☐ Continue ☐ Discontinue ☐ Completed**Goal #3:**

CANS Item(s):

Goal 3 Status: ☐ New ☐ Continue ☐ Discontinue ☐ Completed**Goal #4:**

CANS Item(s):

Goal 4 Status: ☐ New ☐ Continue ☐ Discontinue ☐ Completed**Goal #5:**

CANS Item(s):

Goal 5 Status: ☐ New ☐ Continue ☐ Discontinue ☐ Completed

14. TREATMENT OBJECTIVES		Date Last Updated:
Treating Provider(s):	Lead IM+CANS Provider:	
<p>Treatment objectives in Section 14 must correspond to a goal documented in Section 13 above. Section 14 may be completed separately by each individual treatment provider working with the customer and family, but is not required. Updates to treatment objectives must be shared with the lead IM+CANS provider minimally as part of each IM+CANS reassessment. Updates to treatment objectives do not require LPHA signature.</p>		
GOAL 1:		
Clinical Objectives		
Obj. 1a.		
Obj. 1b.		
Obj. 1c.		
GOAL 2:		
Clinical Objectives		
Obj. 2a.		
Obj. 2b.		
Obj. 2c.		
GOAL 3:		
Clinical Objectives		
Obj. 3a.		
Obj. 3b.		
Obj. 3c.		
GOAL 4:		
Clinical Objectives		
Obj. 4a.		
Obj. 4b.		
Obj. 4c.		
GOAL 5:		
Clinical Objectives		
Obj. 5a.		
Obj. 5b.		
Obj. 5c.		
<p>Progress: Use this space to document progress toward treatment objectives and any other useful information that may inform the customer's ongoing plan of care.</p>		

15. RECOMMENDED BEHAVIORAL HEALTH SERVICES/INTERVENTIONS

Section 15 must include all services the LPHA listed below is authorizing within their scope of practice, regardless of funding source. Other recommended services should be documented in sections 16-18, regardless of funding source.

Goal(s)	Service Name	Amount (how much?)	Frequency (how often?)	Duration (how long?)	Rendering Provider (agency or individual practitioner)

16. OTHER HEALTH & HEALTH RELATED SOCIAL NEEDS

- ☐ Access to Food ☐ Educational Testing ☐ Transportation ☐ Financial Assistance ☐ Medical Needs
☐ Clothing ☐ Mentoring ☐ Legal Assistance ☐ Substance Use Disorder Services
☐ Housing ☐ Employment ☐ Immigration Assistance ☐ Other (specify): _____

17. ADDITIONAL ASSESSMENTS/FUNCTIONING EVALUATIONS RECOMMENDED BY LPHA

- ☐ No additional recommendations ☐ Psychological testing ☐ Psychiatric evaluation

18. REFERRALS TO OTHER RESOURCES / PROVIDERS

Use the space below to document information on referrals given to the customer/family and any relevant follow-up actions taken.

19. IM+CANS SIGNATURES

Customer Signature (required for customers 12 years of age or older) ☐ Customer refused

Customer (print name) _____ Signature _____ Date (mm/dd/yyyy) _____

Parent/Legal Guardian Signature ☐ N/A

Parent/Legal Guardian (print name) _____ Signature _____ Date (mm/dd/yyyy) _____

Lead IM+CANS Provider Signatures

Staff Completing (print name) _____ Credentials _____ Signature _____ Date (mm/dd/yyyy) _____

Authorizing LPHA (print name) _____ Credentials _____ Signature _____ Date (mm/dd/yyyy) _____

Other IM+CANS Provider Signatures ☐ N/A

Signatures from each agency delivering services from section 15 above must be obtained as part of each IM+CANS initial and reassessment, as well as any significant updates to the individual plan of care. Signatures from other IM+CANS providers may be obtained after the authorizing LPHA signature.

Contributing Staff (print name) _____ Agency _____ Signature _____ Date (mm/dd/yyyy) _____

Contributing Staff (print name) _____ Agency _____ Signature _____ Date (mm/dd/yyyy) _____

Contributing Staff (print name) _____ Agency _____ Signature _____ Date (mm/dd/yyyy) _____

Contributing Staff (print name) _____ Agency _____ Signature _____ Date (mm/dd/yyyy) _____