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:	Referral Source:

RIN:	Date of Birth:	Sex at Birth:	Gender Identity:	Phone Number:	Primary Language:

Address:	City:	State:	Zip Code:	County:

Interpreter Services: ☐ None required ☐ TDD/TYY ☐ Spoken Language: _____ ☐ American Sign Language ☐ Other: _____

Ethnicity: ☐ Hispanic or Latinx ☐ Unknown ☐ Non-Hispanic or Latinx

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Other: _____ ☐ Black/African American ☐ White ☐ Unknown ☐ Hawaiian Native/Other Pacific Islander ☐ Multi-Race

Marital Status: ☐ Single ☐ Domestic Partnership ☐ Married ☐ Widowed ☐ Divorced ☐ Unknown

Insurance Coverage:	Household Size:	Household Income:

Guardianship Status: ☐ Own guardian ☐ Youth in Care ☐ Biological parent ☐ Other court appointed ☐ Adoptive parent ☐ Other: _____

Living Arrangement:
☐ Private residence ☐ Homeless/shelter ☐ Jail/correctional facility
☐ Foster home ☐ State op. facility (MH/DD) ☐ Other: _____
☐ Supportive/assisted living ☐ Residential/institution

Employment Status:
☐ Self-employed ☐ Military ☐ Employed full-time
☐ Unemployed ☐ Homemaker ☐ Employed part-time
☐ Student ☐ Retired ☐ Unable to work

Education Level: (last completed)
☐ Never attended ☐ Grade 4-5 ☐ H.S. diploma/GED ☐ Trade/technical training ☐ Master's/Doctoral degree
☐ Pre-K/Kindergarten ☐ Grade 6-8 ☐ Some college ☐ Professional certificate ☐ Unknown
☐ Grade 1-3 ☐ Grade 9-12 ☐ Associate's degree ☐ Bachelor's degree

2. ESTABLISHED SUPPORTS

Does the customer have one or more caregivers? ☐ Yes (please complete the Caregiver Addendum) ☐ No

Caregiver or Significant Other Info.
First and Last Name: _____ Relationship to Customer: ☐ Parent ☐ Legal guardian ☐ Other caregiver ☐ Significant Other Phone Number: _____
Address: _____ City: _____ State: _____ Zip Code: _____ County: _____

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
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Other Supports	Agency	Contact Name	Phone	Email
Physician				
School/Daycare				
Counselor/Therapist				
Child Welfare Worker				
ISC/PAS Agent				
Probation Officer				
Other: _____				
Other: _____				
Other: _____				

IM+CANS

Customer Initials: DOB:
Initial ☐ Update ☐ Reassessment ☐

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	☐	☐	Natural or Manmade Disaster	☐	☐	Disruptions in Caregiving / Attachment Losses	☐	☐
Physical Abuse	☐	☐	Family Violence	☐	☐			
Neglect	☐	☐	Community/School Violence	☐	☐	Parental Criminal Behavior	☐	☐
Emotional Abuse	☐	☐	Criminal Activity	☐	☐			
Medical Trauma	☐	☐	War/Terrorism Affected	☐	☐			

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		☐	☐	☐	☐	3+: Impulsivity/Hyperactivity	☐	☐	☐	☐	☐
Anxiety		☐	☐	☐	☐	3+: Anger Control/Frustration Tolerance	☐	☐	☐	☐	☐
Eating Disturbance		☐	☐	☐	☐	6+: Substance Use	☐	☐	☐	☐	☐
Adjustment to Trauma **[A]**		☐	☐	☐	☐	6+: Addictive Behaviors	☐	☐	☐	☐	☐
Atypical/Repetitive Behaviors **[B]**		☐	☐	☐	☐	6+: Psychosis (Thought Disorder)	☐	☐	☐	☐	☐
0-5: Regulatory	☐	☐	☐	☐	☐	6+: Conduct/Antisocial Behavior	☐	☐	☐	☐	☐
0-5: Failure to Thrive	☐	☐	☐	☐	☐	6+: Mania	☐	☐	☐	☐	☐
3-18: Oppositional Behavior	☐	☐	☐	☐	☐	16+: Interpersonal Problems	☐	☐	☐	☐	☐
						21+: Somatization	☐	☐	☐	☐	☐

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

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		☐	☐	☐	☐	6+: Sexually Prob. Behavior	☐	☐	☐	☐	☐
0-5: Self-Harm	☐	☐	☐	☐	☐	6+: Sexual Aggression **[I]**	☐	☐	☐	☐	☐
0-5: Prenatal Care	☐	☐	☐	☐	☐	6+: Bullying Others	☐	☐	☐	☐	☐
0-5: Birth Weight	☐	☐	☐	☐	☐	6+: Non-Suicidal Self-Inj. Beh. (Self-Mut.)	☐	☐	☐	☐	☐
3-21: Flight Risk/Runaway **[G]**	☐	☐	☐	☐	☐	6+: Other Self-Harm (Recklessness)	☐	☐	☐	☐	☐
3+: Suicide Risk **[H]**	☐	☐	☐	☐	☐	6+: Danger to Others **[J]**	☐	☐	☐	☐	☐
3+: Intentional Misbehavior	☐	☐	☐	☐	☐	6+: Fire Setting **[K]**	☐	☐	☐	☐	☐
						6+: Delinquent/Criminal Behavior **[L]**	☐	☐	☐	☐	☐

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		☐	☐	☐	☐	6+: Talents and Interests	☐	☐	☐	☐	☐
Interpersonal/Social Connectedness		☐	☐	☐	☐	6+: Cultural Identity	☐	☐	☐	☐	☐
Natural Supports		☐	☐	☐	☐	6+: Community Connection	☐	☐	☐	☐	☐
Spiritual/Religious		☐	☐	☐	☐	6+: Involvement with Care	☐	☐	☐	☐	☐
Educational Setting		☐	☐	☐	☐	16+: Vocational	☐	☐	☐	☐	☐
0-21: Relationship Permanence	☐	☐	☐	☐	☐	16+: Job History/Volunteering	☐	☐	☐	☐	☐
2+: Resiliency	☐	☐	☐	☐	☐	21+: Self-Care	☐	☐	☐	☐	☐
6+: Optimism	☐	☐	☐	☐	☐						

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	☐	☐	☐	☐	Cultural Stress	☐	☐	☐	☐
Traditions and Rituals	☐	☐	☐	☐					

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
_____	_____	☐
_____	_____	☐
_____	_____	☐
_____	_____	☐
_____	_____	☐

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

CANS Actionable Items to Consider for Care Planning

Background – Trauma Experiences

Item: ☐ Y ☐ N
Item: ☐ Y ☐ N
Item: ☐ Y ☐ N

Background – Other Needs

Item: ☐ 2 ☐ 3
Item: ☐ 2 ☐ 3
Item: ☐ 2 ☐ 3

Treatment Target Needs

Item: ☐ 2 ☐ 3
Item: ☐ 2 ☐ 3
Item: ☐ 2 ☐ 3
Item: ☐ 2 ☐ 3
Item: ☐ 2 ☐ 3

Anticipated Outcome Needs

Item: ☐ 2 ☐ 3
Item: ☐ 2 ☐ 3
Item: ☐ 2 ☐ 3
Item: ☐ 2 ☐ 3
Item: ☐ 2 ☐ 3

Centerpiece/Useful Strengths

Item: ☐ 0 ☐ 1
Item: ☐ 0 ☐ 1
Item: ☐ 0 ☐ 1
Item: ☐ 0 ☐ 1

Strengths to Build

Item: ☐ 2 ☐ 3
Item: ☐ 2 ☐ 3
Item: ☐ 2 ☐ 3
Item: ☐ 2 ☐ 3

Caregiver Resources

Item: ☐ 0 ☐ 1
Item: ☐ 0 ☐ 1
Item: ☐ 0 ☐ 1

Caregiver Needs

Item: ☐ 2 ☐ 3
Item: ☐ 2 ☐ 3
Item: ☐ 2 ☐ 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

Customer Initials:	DOB:
Initial ☐ Update ☐ Reassessment ☐	

14. TREATMENT OBJECTIVES	Date Last Updated:
Lead IM+CANS Provider:	
Other Treating Provider(s):	

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.

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.	

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.

Customer Initials: **DOB:**
Initial ☐ Update ☐ Reassessment ☐

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 (see IM+CANS Appendix A for key)	Amount (how much?)	Frequency (how often?)	Duration (how long?)	Rendering Provider (list only 1 agency or individual practitioner)

16. OTHER HEALTH & HEALTH RELATED SOCIAL NEEDS

☐ Access to Food ☐ Educational Testing ☐ Employment ☐ Financial Assistance ☐ Medical Needs
☐ Clothing ☐ Mentoring ☐ Transportation ☐ Substance Use Disorder Services
☐ Housing ☐ Tutoring ☐ Legal Assistance ☐ 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) _____