



<input type="checkbox"/> Initial
<input type="checkbox"/> Re-assessment
<input type="checkbox"/> Discharge

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

### 1. GENERAL INFORMATION

Client First and Last Name:	Date of Birth:	RIN:	Gender:	Referral Source:	Date First Contact:
-----------------------------	----------------	------	---------	------------------	---------------------

Phone Number:	Primary Language:	Interpreter Services: <input type="checkbox"/> None required <input type="checkbox"/> TDD/TYY <input type="checkbox"/> Spoken Language: _____ <input type="checkbox"/> American Sign Language <input type="checkbox"/> Other: _____
---------------	-------------------	--

Address:	City:	State:	Zip Code:	County:
----------	-------	--------	-----------	---------

US Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No	Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American	Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Hawaiian Native/Other Pacific Islander <input type="checkbox"/> Multi-Race	White <input type="checkbox"/> White <input type="checkbox"/> Other: _____	Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
--	--	---	--	--

Insurance Coverage and Company: <input type="checkbox"/> N/A	Household Size:	Household Income:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	Divorced <input type="checkbox"/> Divorced	Widowed <input type="checkbox"/> Widowed	Domestic Partnership <input type="checkbox"/> Domestic Partnership
--	-----------------	-------------------	--	---	---	---

Guardianship Status: <input type="checkbox"/> Own guardian <input type="checkbox"/> Biological Parent <input type="checkbox"/> Adoptive Parent	Youth in Care <input type="checkbox"/> Youth in Care <input type="checkbox"/> Other court appointed <input type="checkbox"/> Other: _____	Employment Status: <input type="checkbox"/> Self-employed <input type="checkbox"/> Student <input type="checkbox"/> Homemaker	Military <input type="checkbox"/> Military <input type="checkbox"/> Retired <input type="checkbox"/> Unable to work	Employed full-time <input type="checkbox"/> Employed full-time <input type="checkbox"/> Employed part-time <input type="checkbox"/> Unemployed
---	--	--	--	---

Living Arrangement: <input type="checkbox"/> Lives alone <input type="checkbox"/> Independent Living <input type="checkbox"/> Lives with parent(s), relative(s), or guardian(s) <input type="checkbox"/> State operated facility (mental health/dev. disability) <input type="checkbox"/> Jail or correctional facility	Residential/Institutional Setting (residential, nursing home, shelter) <input type="checkbox"/> Residential/Institutional Setting (residential, nursing home, shelter) <input type="checkbox"/> Community integrated living arrangement (CILA) <input type="checkbox"/> Foster Care <input type="checkbox"/> Homeless <input type="checkbox"/> Other: _____
--	--

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

Parent, Guardian, or Significant Other Info.	First and Last Name:	Relationship to Client: <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> 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
				<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

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

<b>Client Initials:</b> <b>DOB:</b>
--

For the **Trauma Exposure Domain**, use the following categories and action levels:  
 No = Unknown, not currently disclosed, or no evidence of any trauma of this type.  
 Yes = Individual has had experience, either in the past or currently, or there is suspicion that they have experienced this type of trauma - one incident, multiple incidents, or chronic, ongoing experiences.

**POTENTIALLY TRAUMATIC EXPOSURES**

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

**Supporting Information:** Provide additional information on the type of trauma experienced by the individual (indicators rated "yes") and the age of occurrence. Other trauma exposures not captured by an indicator above may be documented here.

Client Initials:
DOB:

For the **Behavioral/Emotional Needs Domain**, use the following categories and action levels:

- 0 No evidence of any needs; no need for action.
- 1 Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.
- 2 Need is interfering with functioning. Action is required to ensure that the identified need is addressed.
- 3 Need is dangerous or disabling; requires immediate and/or intensive action.

**BEHAVIORAL/EMOTIONAL NEEDS DOMAIN**

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

**[A] Traumatic Stress Symptoms (All Ages)**

Emotional and/or Physical Dysregulation	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Intrusions/Re-experiencing	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Hyperarousal	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Attachment Difficulties	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Traumatic Grief & Separation	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Numbing	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Dissociation	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Avoidance	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

**[B] Developmental Needs (All Ages)**

Cognitive Developmental	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Self-Care/Daily Living Skills	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
Autism Spectrum	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	
6+: Sensory	NA <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6+: Motor	NA <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6+: Regulatory	NA <input type="checkbox"/>	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

**Supporting Information:** Provide additional information regarding presenting situation and symptoms (indicators rated "2" or "3" from the Behavioral/Emotional Needs domain and Modules A and B).

Client Initials: DOB:
--------------------------

For the **Life Functioning Domain**, use the following categories and action levels:

- 0 No evidence of any needs; no need for action.
- 1 Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.
- 2 Need is interfering with functioning. Action is required to ensure that the identified need is addressed.
- 3 Need is dangerous or disabling; requires immediate and/or intensive action.

**LIFE FUNCTIONING DOMAIN**

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

\* Complete Developmental Needs Module on Pg. 3

**[C] School/Preschool/Daycare (Ages 0-21)**

School/Preschool/Daycare Behavior	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
School/Preschool/Daycare Achievement	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
School/Preschool/Daycare Attendance	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Relationships with Teachers	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

**[D] Vocational/Career (Ages 16+)**

Career Aspirations	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Job Time	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Job Attendance	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Job Performance	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Job Relations	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Job Skills	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

**[L] Justice/Crime (Ages 6+)**

Seriousness	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
History	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Arrests	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Planning	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Community Safety	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Legal Compliance	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Peer Influences	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Environmental Influences	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

Client Initials: DOB:
--------------------------

**[E] Parenting/Caregiving (Ages 16+)**

Knowledge of Needs	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
Supervision	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
Involvement with Care	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
Organization	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
Marital/Partner Violence in the Home	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>

**[F] Independent Activities of Daily Living (Ages 16+)**

Meal Preparation	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
Shopping	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
Housework	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
Money Management	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
Communication Device Use	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>
Housing Safety	0	<input type="checkbox"/>	1	<input type="checkbox"/>	2	<input type="checkbox"/>	3	<input type="checkbox"/>

---

**Supporting Information:** Information on the impact of the presenting situation on the individual's functioning (indicators rated "2" or "3" from the Life Functioning domain or Modules B-F) should also be included in the narrative.

---

Client Initials:
DOB:

For the **Risk Behaviors Domain**, use the following categories and action levels:

- 0 No evidence of any needs or risk behaviors; no need for action.
- 1 Need or risk behavior requires monitoring, watchful waiting, or preventive action based on history, suspicion or disagreement.
- 2 Need or risk behavior is interfering with functioning. Action is required to ensure that the identified need is addressed.
- 3 Need or risk behavior is dangerous or disabling. Intensive and/or immediate action is required to address the need or risk behavior.

**RISK BEHAVIORS DOMAIN**

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

\* Complete Justice/Crime Module on Pg. 4

**[G] Runaway (Ages 3-21)**

Frequency of Running	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Consistency of Destination	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Safety of Destination	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Involvement in Illegal Activities	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Likelihood of Return on Own	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Realistic Expectations	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Planning	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

**[H] Suicide Risk (Ages 3+)**

Ideation	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Intent	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Planning	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
History of Attempts	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Awareness of Others' Suicide	0 <input type="checkbox"/>	1 <input type="checkbox"/>		

**[I] Sexually Aggressive Behavior (Ages 6+)**

Relationship	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Physical Force/Threat/Coercion	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Planning	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Age Differential	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Power Differential	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Type of Sex Act	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Response to Accusation	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

**[J] Dangerousness (Ages 6+)**

Emotional/Behavioral Risks				
Hostility	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Paranoid Thinking	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Secondary Gains from Anger	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Violent Thinking	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Planning	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Intent	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Violence History	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Resiliency Factors				
Awareness of Violence Potential	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Response to Consequences	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Commitment to Self-Control	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

**[K] Fire Setting (Ages 6+)**

History	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Seriousness	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Planning	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Use of Accelerants	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Intention to Harm Community	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Safety	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Response to Accusation	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Remorse	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
Likelihood of Future Fire Setting	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

<b>Client Initials:</b> <b>DOB:</b>
--

---

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

---

**Factors in Current Environment**

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

---

**PLACEMENT HISTORY**

Describe previous and current out of home placements for the individual (e.g., shelters, foster care, group home, nursing home).  
 Individual has not had any out of home placements.

---

**PSYCHIATRIC INFORMATION**

**General Mental Health History**

Has the individual ever had a psychological evaluation?     No     Yes    Date: \_\_\_\_\_    IQ: \_\_\_\_\_  
Has the individual ever had a psychiatric evaluation?     No     Yes    Date: \_\_\_\_\_

---

Client Initials: DOB:
--------------------------

**Prior Mental Health Treatment**

Describe any prior mental health treatment the individual 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 individual's current mental status as noted above.



Client Initials: DOB:
--------------------------

For the **Strengths Domain**, use the following categories and action levels:

- 0 Well-developed, centerpiece strength; may be used as a centerpiece in an intervention/action plan.
- 1 Identified and useful strength. Strength will be used, maintained, or built upon as part of the plan. May require some effort to develop strength into a centerpiece strength.
- 2 Strengths have been identified but require strength-building efforts before they can be effectively utilized as part of a plan. Identified but not useful.
- 3 An area in which no current strength is identified; efforts may be recommended to develop a strength in this area.

**STRENGTHS DOMAIN**

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

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

Client Initials: DOB:
--------------------------

**FAMILY INFORMATION**

**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).

For the **Cultural Needs Domain**, use the following categories and action levels:

- 0 No evidence of any needs; no need for action.
- 1 Identified need that requires monitoring, watchful waiting, or preventive action based on history, suspicion, or disagreement.
- 2 Need is interfering with functioning. Action is required to ensure that the identified need is addressed.
- 3 Need is dangerous or disabling; requires immediate and/or intensive action.

**CULTURAL NEEDS DOMAIN**

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

Culture Stress	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
----------------	----------------------------	----------------------------	----------------------------	----------------------------

**Supporting Information:** Provide additional information regarding the cultural needs (indicators 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).

<b>Client Initials:</b> <b>DOB:</b>
--

**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 individual's diagnosis not captured elsewhere in the IM+CANS (e.g., rule out diagnoses, outputs of diagnostic assessments that helped inform the listed diagnosis).

**MENTAL HEALTH ASSESSMENT SUMMARY**

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

---

Client Initials: DOB:
--------------------------

**12. SUMMARY OF PRIORITIZED CANS NEEDS AND STRENGTHS**

CANS Actionable Items to Consider for Care Planning			
<b>Background – Trauma Experiences</b>		<b>Background – Other Needs</b>	
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
<b>Treatment Target Needs</b>		<b>Anticipated Outcome Needs</b>	
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
<b>Centerpiece/Useful Strengths</b>		<b>Strengths to Build</b>	
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
<b>Caregiver Resources</b>		<b>Caregiver Needs</b>	
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. Individual and Family Vision Statement**

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

---

**13b. Individual and Family Service Preferences.**

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

---

**13c. Individual and Family Centered Goals.**

Goals should be stated in individual/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 individuals working with multiple behavioral health providers or in care coordination programs, this should include all treatment goals addressed across all treatment providers.

<p><b>Goal #1:</b></p> <p>CANS Item(s):</p> <p>Goal 1 Status: <input type="checkbox"/> New <input type="checkbox"/> Continue <input type="checkbox"/> Discontinue <input type="checkbox"/> Completed</p>
<p><b>Goal #2:</b></p> <p>CANS Item(s):</p> <p>Goal 2 Status: <input type="checkbox"/> New <input type="checkbox"/> Continue <input type="checkbox"/> Discontinue <input type="checkbox"/> Completed</p>
<p><b>Goal #3:</b></p> <p>CANS Item(s):</p> <p>Goal 3 Status: <input type="checkbox"/> New <input type="checkbox"/> Continue <input type="checkbox"/> Discontinue <input type="checkbox"/> Completed</p>
<p><b>Goal #4:</b></p> <p>CANS Item(s):</p> <p>Goal 4 Status: <input type="checkbox"/> New <input type="checkbox"/> Continue <input type="checkbox"/> Discontinue <input type="checkbox"/> Completed</p>
<p><b>Goal #5:</b></p> <p>CANS Item(s):</p> <p>Goal 5 Status: <input type="checkbox"/> New <input type="checkbox"/> Continue <input type="checkbox"/> Discontinue <input type="checkbox"/> Completed</p>

Client Initials: DOB:
--------------------------

**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 individual 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 individual's ongoing plan of care.

**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 individual/family and any relevant follow-up actions taken.

**19. IM+CANS SIGNATURES**

**Individual Signature** (required for individuals 12 years of age or older)  Individual refused

\_\_\_\_\_ Signature \_\_\_\_\_ Date (mm/dd/yyyy)

**Parent/Legal Guardian Signature**  N/A

\_\_\_\_\_ Signature \_\_\_\_\_ Date (mm/dd/yyyy)

**Lead IM+CANS Provider Signatures**

\_\_\_\_\_ Credentials \_\_\_\_\_ Signature \_\_\_\_\_ Date (mm/dd/yyyy)

\_\_\_\_\_ 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.

\_\_\_\_\_ Agency \_\_\_\_\_ Signature \_\_\_\_\_ Date (mm/dd/yyyy)

\_\_\_\_\_ Agency \_\_\_\_\_ Signature \_\_\_\_\_ Date (mm/dd/yyyy)

\_\_\_\_\_ Agency \_\_\_\_\_ Signature \_\_\_\_\_ Date (mm/dd/yyyy)

\_\_\_\_\_ Agency \_\_\_\_\_ Signature \_\_\_\_\_ Date (mm/dd/yyyy)