MACOMB COUNTY COMMUNITY MENTAL HEALTH - FOCUS ANNUAL ASSESSMENT

Name: **Case #:** **Case:**

Date of Birth **Home Phone** **Current Admission**

Address **Primary Program:**
Case Holder:

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1. Annual Assessment: Basic Information - Demographics

Please verify Information

Date of Annual Assessment **Time of Annual Assessment**

Use Current Date

Last Name **First Name** **MI**

Address **County of Residence**

Home Phone ( ) - x **Primary Phone**

Cell Phone ( ) - x ○ Home ○ Cell ○ Alternate ○ None

Alternate Phone ( ) - x

City **State** **Zip** lookup **Email**

Residential Living Arrangement

- ○ Unknown
- ○ Living in private residence with natural or adoptive family member(s).
- ○ Living in private residence not owned by CMH/provider, alone or w/spouse or non-relative(s).
- ○ Homeless on the street or in a shelter for the homeless
- ○ Prison/jail/juvenile detention center
- ○ Nursing Care Facility
- ○ Institutional setting (congregate care facility, boarding schools, Child Caring Institutions, state facilities)
- ○ Private residence that is owned by PIHP, CMHSP, or contracted provider
- ○ Foster family home
- ○ Specialized residential home
- ○ General residential home

Number of Beds in Residential or Institutional Setting

○ 1-3 ○ 4-6 ○ 7-15 ○ 16+ ◉ Unknown or N/A

Date of Birth **SSN**

Place Of Birth (city and state if born in the USA, city and country if born in a foreign country)

MI Child ID # lookup **Medicaid ID #** lookup

Aliases and Other Identifying Information that can be used to search for a consumer

characters left: 256

Group Home/Residential Facility lookup clear

Gender

- ○ Male
- ◉ Female

Marital Status

- ○ Divorced
- ○ Married
- ○ Never Married
- ○ Separated
- ○ Widowed

Race / Ethnic Origin 1

- ○ N/A
- ○ White
- ○ Black or African American
- ○ American Indian or Alaskan Native
- ○ Asian
- ○ Native Hawaiian or other Pacific Islander
- ○ Some other race
- ○ Unknown Race
- ○ Consumer Refused to Provide Information

Race / Ethnic Origin 2

- ○ N/A
- ○ White
- ○ Black or African American
- ○ American Indian or Alaskan Native
- ○ Asian
- ○ Native Hawaiian or other Pacific Islander
- ○ Some other race
- ○ Unknown Race
- ○ Consumer Refused to Provide Information

Race / Ethnic Origin 3

- ○ N/A
- ○ White
- ○ Black or African American
- ○ American Indian or Alaskan Native
- ○ Asian
- ○ Native Hawaiian or other Pacific Islander
- ○ Some other race
- ○ Unknown Race
- ○ Consumer Refused to Provide Information

Ethnicity / Cultural Identity

Hispanic or Latino / Latina

○ Yes ○ No ○ Unknown

Arab American / Chaldean

○ Yes ○ No ○ Unknown

Primary Spoken Language

Religion

Veteran Status

○ Yes ○ No ○ Unknown

Parental Status (Has child under 18)

○ Yes ○ No

Department of Human Services

Child currently served by DHS for abuse and neglect ○ Yes ○ No

Child currently served by another DHS program ○ Yes ○ No

Child Enrolled in Early On

If consumer is an adult or a child NOT enrolled in Early On, select 'No'

○ Yes ○ No

Wraparound Service

○ Yes ○ No

Contact / Mailing Information

Select the Mail Recipient for this Consumer

○ Consumer ○ Guardian ○ Parent ○ Spouse ○ Do not Mail ○ Other

☐ Do Not Mail

☐ Do Not Call

Accommodations

characters left: 256

Will cultural considerations be a barrier to service?

Yes No

Comments

characters left: 1024

✓Spell Check

Save and Continue to Contacts | Save | CANCEL

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Case Holder:

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1. Intake Assessment: Basic Information - Contacts

Person Residing in Consumer's Home (complete if residing in private residence)

Name	Year of Birth	Relationship	
			clear
			clear
			clear
			clear
			clear
			clear

Add More Household Members

Other Emergency Contact

Clear Information | History

Last Name **First Name**

Phone Number **Primary Phone**
- Home
- Cell
- Alternate
- None

Cell Phone

Alt Phone

Email

Address

City **State** **Zip** lookup

MI

Not a US Address

Check if address is Same as Consumer

Relationship
- Mother
- Father
- Child
- Legal Guardian
- Spouse
- Unrelated
- Sibling
- Other

Additional Contact

Clear Information | History

Last Name **First Name**

Phone Number **Primary Phone**
- Home
- Cell
- Alternate
- None

Cell Phone

Alt Phone

Email

Address

City | State | Zip lookup

MI

Not a US Address

Check if address is Same as Consumer

more

Relationship

Mother Father

Child Legal Guardian

Spouse Unrelated

Sibling

Other

✓Spell Check

Record Added

Record Changed

Save and Continue to Guardians | Save | CANCEL

Back | Home

Name: **Case #:** **Case:**

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Address **Case Holder:**

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1. **Basic Information**
   a. Demographics
   b. Contacts
   c. **Guardians**
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3. Health Conditions
4. Education & Employment
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7. Risk Assessment
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10. Substance Abuse Chart(MI/SED)
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13. Diagnosis
14. Recommendations for Continued Treatment
15. Send Copy to
16. Signatures

1. Intake Assessment: Basic Information - Guardians

Legal Guardian

○ No Guardianship in Place ○ Parent(s) of Minor Child ○ Court Appointed Guardian

Parent(s) of Minor Child Authorized to Consent to Treatment Clear Information

Mother Clear Information

○ Biological Mother ○ Adoptive Mother

First Name **Last Name**

☐ **Check if address is same as consumer - provide address if not the same**

Address **Home Phone** **Primary Phone**

○ Home

Cell Phone ○ Cell

○ Alternate

City **State** **Zip** lookup **Alternate Phone** ○ None

☐ Not a US Address

Email

Father Clear Information

○ Biological Father ○ Adoptive Father

First Name **Last Name**

☐ **Check if address is same as consumer - provide address if not the same**

Address **Home Phone** **Primary Phone**

○ Home

Cell Phone ○ Cell

○ Alternate

City **State** **Zip** lookup **Alternate Phone** ○ None

☐ Not a US Address

Email

Divorce Information Clear Information

If Parents are Divorced, Indicate Child Custody Status

Legal Custody: ○ Sole-Mother ○ Sole-Father ○ Joint ○ Unknown

Physical Custody: ○ Sole-Mother ○ Sole-Father ○ Joint ○ Unknown

Copy of Divorce Papers Scanned into FOCUS?

○ Yes ○ No ○ See Hybrid (Paper) Record

Additional Information Related to Parent Consent

characters left: 1024

Court Appointed Guardian Clear Information

First Name **Last Name**

☐ **Check if address is Same as Consumer**

Address **Home Phone** **Primary Phone**

City State Zip lookup

Not a US Address

Cell Phone

Alternate Phone

Home
Cell
Alternate
None

Email

Type of Guardianship

Plenary of Person | Plenary of Estate | Plenary of Person and Estate
Guardian Ad Litem | DHS Ward - Permanent | DHS Ward - Temporary
Partial Describe Powers:

Guardian's Relationship to Consumer

Mother | Father | Child
Spouse | Sibling | Public Guardian
Unrelated | Other

Date of Court Order

Expiration Date

Copy of Guardianship Papers Scanned into FOCUS?

Yes No See Hybrid (Paper) Record

Co-Guardian Information

Clear Information

First Name

Last Name

Check if address is Same as Consumer

Address

City State Zip lookup

Not a US Address

Home Phone

Cell Phone

Alternate Phone

Primary Phone
Home
Cell
Alternate
None

Email

Type of Guardianship

Plenary of Person | Plenary of Estate | Plenary of Person and Estate
Guardian Ad Litem | DHS Ward - Permanent | DHS Ward - Temporary
Partial Describe Powers:

Guardian's Relationship to Consumer

Mother | Father | Child
Spouse | Sibling | Public Guardian
Unrelated | Other

Date of Court Order

Expiration Date

Copy of Guardianship Papers Scanned into FOCUS?

Yes No See Hybrid (Paper) Record

Standby Guardian Information

Clear Information

First Name

Last Name

Check if address is Same as Consumer

Address

City State Zip lookup

Home Phone

Cell Phone

Primary Phone
Home
Cell
Alternate

Alternate Phone

None

Not a US Address

Email

Type of Guardianship

Plenary of Person | Plenary of Estate | Plenary of Person and Estate

Guardian Ad Litem | DHS Ward - Permanent | DHS Ward - Temporary

Partial Describe Powers:

Guardian's Relationship to Consumer

Mother | Father | Child

Spouse | Sibling | Public Guardian

Unrelated | Other

Date of Court Order

Expiration Date

Copy of Guardianship Papers Scanned into FOCUS?

Yes | No | See Hybrid (Paper) Record

Additional Guardianship Information

characters left: 1024

✓Spell Check

Record Added **Record Changed**

Save and Continue to Medical Information | Save | CANCEL

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Case Holder:

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2. Intake Assessment: Medical Information

Please verify Information

Consumer has Primary Physician (PHCP)

○ Yes ○ No Date last seen: QHP:

Does consumer need assistance finding a PHCP?

○ Yes ○ No

Physicians

Location: ☐ Primary Care Physician (PHCP)

Date of Last Visit

PHCP Name: lookup

Location: ☐ Primary Care Physician (PHCP)

Date of Last Visit

PHCP Name: lookup

Add Physician to List

Prescribed Medications

Medication	Dates	Prescribed By	Qty Prescribed

Show/Hide Medication Information

Other Medications

	Medication	Medication Type	Dates	Prescribing Physician Info

Add new other medications for the client below.

Medication lookup clear ☐ Edit name (if not found)

Medication: Dosage: Qty:

Medication Type **Dates**

Start: End:

Instructions **Reason**

Prescribing Physician **Prescribing Physician Type**

Medication lookup clear ☐ Edit name (if not found)

Medication: Dosage: Qty:

Medication Type **Dates**

Start: End:

Instructions

Reason

Prescribing Physician

Prescribing Physician Type

Medication lookup clear

Edit name (if not found)

Medication:

Dosage: Qty:

Medication Type

Dates

Start: End:

Instructions

Reason

Prescribing Physician

Prescribing Physician Type

Add More Medications

✓Spell Check

Record Added **Record Changed**

Save and Continue to Health Conditions | Save | CANCEL

Back | Home

Name: **Case #:** **Case:**

Date of Birth **Home Phone** **Current Admission**

Address **Primary Program:**
Case Holder:

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3. Intake Assessment: Health Conditions

Health and Other Conditions

Hearing

Ability to hear (with hearing appliance normally used)

- ○ Adequate
  No difficulty in normal conversation, social interaction, listening to TV
- ○ Minimal difficulty
  Difficulty in some environments (e.g., when person speaks softly or is more than 6 feet away)
- ○ Moderate difficulty
  Problem hearing normal conversation, requires quiet setting to hear well
- ○ Severe difficulty
  Difficulty in all situations (e.g., speaker has to talk loudly or speak very slowly; or person reports that all speech is mumbled)
- ○ No hearing

Hearing aid used

○ Yes ○ No

Vision

Ability to see in adequate light (with glasses or with other visual appliance normally used)

- ○ Adequate
  Sees fine detail, including regular print in newspapers/books or small items in pictures
- ○ Minimal difficulty
  Sees large print, but not regular print in newspapers/books or cannot identify large objects in pictures
- ○ Moderate difficulty
  Limited vision; not able to see newspaper headlines or small items in pictures, but can identify objects in his/her environment
- ○ Severe difficulty
  Object identification in question, but the person's eyes appear to follow objects, or the person sees only light, colors, shapes
- ○ No vision
  Eyes do not appear to follow objects; absence of sight

Visual appliance used

○ Yes ○ No

Health Conditions

Indicate whether or not the individual had the presence of each of the following health conditions, as reported by the individual, a health care professional or family member, in the past 12 months.

Pneumonia (2 or more times) - including Aspiration Pneumonia

- ○ Never present
- ○ History of condition, but not treated for the condition within the past 12 months
- ○ Treated for the condition within the past 12 months
- ○ Information unavailable

Asthma

- ○ Never present

- History of condition, but not treated for the condition within the past 12 months
- Treated for the condition within the past 12 months
- Information unavailable

Upper Respiratory Infections (3 or more times within past 12 months)

These infections may affect the throat, nasal cavity, sinuses, larynx or bronchi

- Never present
- History of condition, but not treated for the condition within the past 12 months
- Treated for the condition within the past 12 months
- Information unavailable

Gastroesophageal Reflux, or GERD

- Never present
- History of condition, but not treated for the condition within the past 12 months
- Treated for the condition within the past 12 months
- Information unavailable

Chronic Bowel Impactions

- Never present
- History of condition, but not treated for the condition within the past 12 months
- Treated for the condition within the past 12 months
- Information unavailable

Seizure disorder or Epilepsy

- Never present
- History of condition, but not treated for the condition within the past 12 months
- Treated for the condition within the past 12 months and seizure free
- Treated for the condition within the past 12 months, but still experience occasional seizures (less than one per month)
- Treated for the condition within the past 12 months, but still experience frequent seizures
- Information unavailable

Progressive neurological disease, include, Alzheimer's and Parkinson's disease

- Not present
- Treated for the condition within the past 12 months
- Information unavailable

Diabetes

- Never present
- History of condition, but not treated for the condition within the past 12 months
- Treated for the condition within the past 12 months
- Information unavailable

Hypertension

- Never present
- History of condition, but not treated for the condition within the past 12 months
- Treated for condition within the past 12 months and blood pressure is stable
- Treated for condition within the past 12 months, but blood pressure remains high or unstable
- Information is unavailable

Obesity

- ○ Not present
- ○ Medical diagnosis of obesity present or Body Mass Index (BMI) > 30

Pregnant?

○ Yes ○ No ○ N/A

Immunizations current?

○ Yes ○ No

Child Only

Prenatal Exposure To

☐ Tobacco ☐ Alcohol ☐ Other Drugs

Current Exposure To

☐ Tobacco ☐ Alcohol ☐ Other Drugs

Tobacco Use ☐ Declined ☐ No Information Collected

Smoking Status / Tobacco Use

Provided consumer with advice to quit smoking or tobacco use, or recommended or discussed smoking or tobacco use cessation, medications, methods, or strategies

○ Yes ○ No

Pain

Scale (0=none, 10=severe)

Location of Pain

Treatment

characters left: 256

Controlled

○ Yes ○ No

Medical Issues (include communicable diseases)

☐ None Reported

characters left: 30000

✓Spell Check

Record Added **Record Changed**

Save and Continue to Education & Employment | Save | CANCEL

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Name: **Case #:** **Case:**

Date of Birth **Home Phone** **Current Admission**

Address **Primary Program:**
Case Holder:

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4. Intake Assessment: Education & Employment

Please verify Information

Education

- ○ Unknown / Unreported
- ○ Completed less than high school
- ○ Completed special education, high school, or GED
- ○ In school - Kindergarten through 12th grade
- ○ In training program
- ○ In Special Education
- ○ Attended or is attending undergraduate college
- ○ College graduate

Highest Grade

School Name and Location:

If in Special Ed, specify type

- ○ Emotionally Impaired (EI)
- ○ Cognitive Impaired (CI)
- ○ Severely Multiply Impaired (SXI)
- ○ Autistic Impaired (AI)
- ○ Other Health Impairment (OHI)
- ○ Not Applicable

Employment Status

- ○ Employed full time (30 hours or more per week) competitively
- ○ Employed part time (less than 30 hours per week) in competitively
- ○ Unemployed - looking for work, and/or on layoff from job
- ○ Participates in sheltered workshop or facility-based work
- ○ In unpaid work (e.g. volunteering, internship, community service)
- ○ Self-employed (e.g. micro-enterprise)
- ○ In enclaves/mobile crews, agency-owned transitional employment
- ○ Participates in facility-based activity program where specialty supports and services are provided to assist an individual in achieving non-work related goals
- ○ Not in the competitive labor force – includes homemaker, child, student, retired, resident of an institution, or incarcerated

Earned wage is Minimum Wage or greater

○ Yes ○ No ○ N/A - Person is not working

If employed, occupation:

✓Spell Check

Record Added **Record Changed**

Name: **Case #:** **Case:**

Date of Birth **Home Phone** **Current Admission**

Address **Primary Program:**
Case Holder:

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5. Intake Assessment: Current Corrections Related Status

Please verify Information

Corrections Related Status

- ○ Unknown
- ○ Not under the jurisdiction of a corrections or law enforcement program
- ○ In prison
- ○ Consumer refused to provide information
- ○ Minor (under age 18) who was referred by the court
- ○ Arrested and booked
- ○ Diverted from arrest or booking
- ○ In jail
- ○ Paroled from prison
- ○ Probation from jail
- ○ Juvenile detention center
- ○ Court supervision
- ○ Awaiting trial
- ○ Awaiting sentencing

Drug Court Client ○ Yes ○ No

On Sex Offender Registry ○ Yes ○ No

MPRI ○ Yes ○ No

Arrest History

	Last 30 Days	Last 5 Years
Total Arrests		
Possession / Sales		
DUI / DWI		

Narrative

characters left: 30000

✓Spell Check

Record Added **Record Changed**

Save and Continue to Presenting Problems | Save | CANCEL

Back | Home

Name: **Case #:** **Case:**

Date of Birth **Home Phone** **Current Admission**

Address **Primary Program:** Unassigned
Case Holder: Unassigned

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6. Intake Assessment: Presenting Problems

Please verify Information

Presenting Problem/Reason For Initial Service Request

characters left: 30000

Reason For Continued Service

(Include area of the person's life that were the focus over the past year. What was tried? What was effective? Identify any stressors the client/family is dealing with.)

characters left: 30000

✓Spell Check

Record Added **Record Changed**

Save and Continue to Risk Assessment | Save | CANCEL

Back | Home

Name: **Case #:** **Case:**

Date of Birth **Home Phone** **Current Admission**

Address

Primary Program:
Case Holder:
Disability Designation:

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7. Annual Assessment: Risk Assessment

Please verify Information

SUICIDAL

	Present (< 30 days)	Recent (> 30 days - 1 year)	Past (> 1 year)
Ideation / Threat	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Attempt	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

Comments

characters left: 30000

HOMICIDAL

	Present (< 30 days)	Recent (> 30 days - 1 year)	Past (> 1 year)
Ideation / Threat	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Intent	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Plan	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Attempt	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

Comments

characters left: 30000

TRAUMA

Experienced ○ Yes ○ No

Witnessed ○ Yes ○ No

	Present (< 30 days)	Recent (> 30 days - 1 year)	Past (> 1 year)
Abuse - Sexual	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Abuse - Verbal/Emotional	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Violence	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Neglect	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Environmental	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

Description Of Trauma

characters left: 30000

HARM

	Present (< 30 days)	Recent (> 30 days - 1 year)	Past (> 1 year)

Self (Cutting, Binging/Purging, Alcohol/Drugs, & other Risky Behaviors)	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Others - Sexual	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Others - Physical	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Others - Verbal/Emotional	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No

Comments

characters left: 30000

Immediate Action Needed?

○ Yes ○ No

Involve

- ☐ Supervisor
- ☐ Hospital
- ☐ Police
- ☐ Protective Services (APS / CPS)
- ☐ Other

Describe Action Taken

characters left: 30000

✓Spell Check

Record Added **Record Changed**

Save and Continue to Mental Status (MI/SED) | Save | CANCEL

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8. Intake Assessment: Mental Status (MI/SED)

Please verify Information

General Behavior

- ☐ Cooperative
- ☐ Hostile
- ☐ Restless
- ☐ Passive
- ☐ Agitated
- ☐ Guarded
- ☐ Dramatic
- ☐ Withdrawn
- ☐ Isolative
- ☐ Other:

characters left: 256

Communication

- ☐ Unremarkable
- ☐ Soft
- ☐ Loud
- ☐ Pressured
- ☐ Slurred
- ☐ Immature
- ☐ American Sign Language
- ☐ Non-verbal
- ☐ Other:

characters left: 256

Perceptions

- ☐ Normal
- ☐ Delusions
- ☐ Hallucinations
- ☐ Unknown

characters left: 256

Thought Process

- ☐ Unremarkable
- ☐ Tangential
- ☐ Delusions
- ☐ Associations
- ☐ Obsessive
- ☐ Ideas of References
- ☐ Grandiose
- ☐ Circumstantial
- ☐ Paranoid
- ☐ Rumination
- ☐ Loose
- ☐ Unknown

characters left: 256

Mood

- ☐ Normal
- ☐ Fearful
- ☐ Dysphoric
- ☐ Angry
- ☐ Anxious
- ☐ Euphoric
- ☐ Apathetic
- ☐ Expansive

characters left: 256

Judgment

- ○ Good
- ○ Fair
- ○ Poor
- ○ Unknown

If poor, explain:

characters left: 512

Impulse Control

○ Good ○ Fair ○ Poor

If poor, explain:

characters left: 512

Insight

○ Good ○ Fair ○ Poor ○ N/A

characters left: 256

Sleep

○ Normal ○ Increased ○ Decreased ○ Variable

characters left: 256

Appetite

○ Normal ○ Increased ○ Decreased ○ Variable

characters left: 256

✓Spell Check

Record Added **Record Changed**

Save and Continue to Psychiatric and Substance Abuse History(MI/SED)

Save CANCEL

Back Home

Name: **Case #:** **Case:**

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Address **Primary Program:**
Case Holder:

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9. Intake Assessment: Psychiatric and Substance Abuse History(MI/SED)

Please verify Information

MH Treatment History

	Number of episodes	Last Year Used
☐ State Hospital		
☐ Acute Community Hospital/ Intensive Crisis Residential/ Intensive Crisis Stabilization		
☐ ACT/Home Based		
☐ Outpatient / Community Services		

SA Treatment History

Number of prior SA treatment episodes

Outpatient	
IOP	
Residential	
Detox	
Methadone	

Family History of Mental Illness and Substance Abuse

☐ No Family History

Family Member	MI	SA	Disorder
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	
	☐	☐	

UNCOPE - Additional Screening Instrument

Norman H. Hoffman, Ph.D.

U	In the past year, have you ever drank or **USED** drugs more than you meant to? Or, Have you spent more time drinking or using than you intended?	○ Yes ○ No
N	Have you ever **NEGLECTED** some of your usual responsibilities because of using last year?	○ Yes ○ No
C	Have you ever felt you wanted or needed to **CUT DOWN** on your drinking or drug use in the last year?	○ Yes ○ No
O	Has anyone **OBJECTED** to your drinking or drug use? Or, Has your family, a friend, or anyone else ever told you they objected to your alcohol or drug use?	○ Yes ○ No
P	Have you ever found yourself **PREOCCUPIED** with wanting to use alcohol or drugs? Or, Have you found yourself thinking a lot about drinking or using?	○ Yes ○ No
E	Have you ever used alcohol or drugs to relieve **EMOTIONAL DISCOMFORT** such as sadness, anger, or boredom?	○ Yes ○ No

Total Yes 0

Scoring
Two (2) or more positive responses indicate possible abuse or dependence

Four (4) or more positive responses strongly indicate dependence

UNCOPE Results

ASAM Result Complete ASAM Worksheet

Level 0.5:	OMT:	Level I:	Level II.1:	Level II.5:
Level III.1:	Level III.3:	Level III.5:	Level III.7:	Level IV:

Comments

characters left: 8000

Narrative

characters left: 30000

✓ Spell Check

Record Added **Record Changed**

Save and Continue to Substance Abuse Chart(MI/SED) Save

CANCEL

Back Home

Name: **Case #:** **Case:**

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Case Holder:

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10. Intake Assessment: Substance Abuse Chart(MI/SED)

Please verify Information

Add Drug to List

Drug of Choice: **Key** 1 = First Choice - 10 = Last Choice

Number of Days used in the Last 30 Days: 0 = Not Used; 1-29 = No. of Days; 30 = Daily

Method Of Current Dosing: 1 = Oral; 2 = Smoking; 3 = Snorting; 4 = IV; 5 = Other

Type of Drug and Name	Drug of Choice	Age at First Use	Age at Problematic Use	Init.Rx	1- Heaviest Amount Consumed and when 2- Current Consumption	Date of Last Use	Number of days drug used in last 30 days	Method of Current Dosing	
					1 2				
				☐ YES	1 2				
				☐ YES	1 2				
				☐ YES	1 2				
				☐ YES	1 2				
					1 2				
					1 2				
				☐ YES	1 2				
				☐ YES	1 2				
					1 2				
					1 2				

✓Spell Check

Record Added **Record Changed**

Save and Continue to DD Proxy Measures | Save | CANCEL

Back | Home

Name: **Case #:** **Case:**

Date of Birth **Home Phone** **Current Admission**

Address **Primary Program:**
Case Holder:

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11. Intake Assessment: DD Proxy Measures

Please verify Information

Clear Information

Date

Use Current Date

For purposes of these data elements, when the term 'support' is used, it means support from a paid or un-paid person or technological support needed to enable the individual to achieve his/her desired future. The kinds of support a person might need are:
- 'Limited' means the person can complete approximately 75% or more of the activity without support and the caregiver provides support for approximately 25% or less of the activity.
- 'Moderate' means the person can complete approximately 50% of the activity and the caregiver supports the other 50%.
- 'Extensive' means the person can complete approximately 25% of the activity and relies on the caregiver to support 75% of the activity.
- 'Total' means the person is unable to complete the activity and the caregiver is providing 100% of support.

Predominant Communication Style

Indicate from the list below how the individual communicates most of the time

- English language spoken by the individual
- Assistive technology used
  Includes computer, other electronic devices or symbols such as Bliss board, or other 'low tech' communication devices.
- Interpreter used
  This includes a foreign language or American Sign Language (ASL) interpreter, or someone who knows the individual well enough to interpret speech or behavior.
- Alternative language used
  This includes a foreign language, or sign language without an interpreter.
- Non-language forms of communication used
  Gestures, vocalizations or behavior.
- No ability to communicate

Ability to Make Self Understood

Ability to communicate needs, both verbal and non-verbal, to family, friends, or staff
*For reporting children 5 or younger-
Report 'Rarely or Never Understood' when understanding is limited to interpretation of every person-specific sounds or body language and/or a child age 5 or younger is not yet using verbal or non-verbal communication.

- Always Understood
  Expresses self without difficulty
- Usually Understood
  Difficulty communicating BUT if given time and/or familiarity can be understood, little or no prompting required
- Often Understood
  Difficulty communicating AND prompting usually required
- Sometimes Understood
  Ability is limited to making concrete requests or understood only by a very limited number of people
- Rarely or Never Understood
  Understanding is limited to interpretation of very person-specific sounds or body language

Support with Mobility

*For reporting children 5 or younger-
Report 'Moderate Support'-if a child scoots, crawls, creeps on hands and knees, or walks a few steps independently or when holding hands with caregiver.
Report 'Extensive Support'-if a child is primarily carried or transported by a caregiver.

- ○ Independent
  Able to walk (with or without an assistive device) or propel wheelchair and move about
- ○ Guidance/Limited Support
  Able to walk (with or without an assistive device) or propel wheelchair and move about with guidance, prompting, reminders, stand by support, or with limited physical support
- ○ Moderate Support
  May walk very short distances with support but uses wheelchair as primary method of mobility, needs moderate physical support to transfer, move the chair, and/or shift positions in chair or bed
- ○ Extensive Support
  Uses wheelchair exclusively, needs extensive support to transfer, move the wheelchair, and/or shift positions in chair or bed
- ○ Total Support
  Uses wheelchair with total support to transfer, move the wheelchair, and/or shift positions or may be unable to sit in a wheelchair; needs total support to shift positions throughout the day

Mode of Nutritional Intake

*For reporting children 5 or younger-
Report 'Modified independent' if child is bottle fed or eats foods specially prepared by the caregiver to accommodate current developmental needs.

- ○ Normal
  Swallows all types of foods
- ○ Modified independent
  e.g., liquid is sipped, takes limited solid food, need for modification may be unknown
- ○ Requires diet modification to swallow solid food
  e.g., mechanical diet (e.g., purée, minced) or only able to ingest specific foods
- ○ Requires modification to swallow liquids
  e.g., thickened liquids
- ○ Can swallow only puréed solids AND thickened liquids
- ○ Combined oral and parenteral or tube feeding
- ○ Enteral feeding into stomach
  e.g., G-tube or PEG tube
- ○ Enteral feeding into jejunem
  e.g., J-tube or PEG-J tube
- ○ Parenteral feeding only
  Includes all types of parenteral feedings, such as total parenteral nutrition (TPN)

Support with Personal Care

Ability to complete personal care, including bathing, toileting, hygiene, dressing and grooming tasks, including the amount of help required by another person to assist. This measure is an overall estimation of the person's ability in the category of personal care. If the person requires guidance only for all tasks but bathing, where he or she needs extensive support, score 'Guidance/Limited Support' to reflect the overall average ability. The person may or may not use assistive devices like shower or commode chairs, long-handled brushes, etc. Note: assistance with medication should NOT be included.

- ○ Independent
  Able to complete all personal care tasks without physical support
- ○ Guidance/Limited Support
  Able to perform personal care tasks with guidance, prompting, reminding or with limited physical support for less than 25% of the activity
- ○ Moderate Physical Support
  Able to perform personal care tasks with moderate support of another person
- ○ Extensive Support

Able to perform personal care tasks with extensive support of another person

- Total Support

  Requires full support of another person to complete personal care tasks (unable to participate in tasks)

Relationships

Indicate whether or not the individual has 'natural supports' defined as persons outside of the mental health system involved in his/her life who provide emotional support or companionship.

- Extensive involvement, such as daily emotional support/companionship
- Moderate involvement, such as several times a month up to several times a week
- Limited involvement, such as intermittent or up to once a month
- Involved in planning or decision-making, but does not provide emotional support/companionship
- No involvement

Status of Family/Friend Support System

Indicate whether current (unpaid) family/friend caregiver status is at risk in the next 12 months; including instances of caregiver disability/illness, aging, and/or re-location. 'At risk' means caregiver will likely be unable to continue providing the current level of help, or will cease providing help altogether but no plan for replacing the caregiver's help is in place.

- Caregiver status is not at risk
- Caregiver is likely to reduce current level of help provided
- Caregiver is likely to cease providing help altogether
- Family/friends do not currently provide care
- Information unavailable

Support for Accommodating Challenging Behaviors

Indicate the level of support the individual needs, if any, to accommodate challenging behaviors. 'Challenging behaviors' include those that are self-injurious, or place others at risk of harm. (Support includes direct line of sight supervision)

- No challenging behaviors, or no support needed
- Limited Support, such as support up to once a month
- Moderate Support, such as support once a week
- Extensive Support, such as support several times a week
- Total Support - Intermittent, such as support once or twice a day
- Total Support - Continuous, such as full-time support

Presence of a Behavior Plan

Indicate the presence of a behavior plan during the past 12 months.

- No Behavior Plan
- Positive Behavior Support Plan or Behavior Treatment Plan without restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee
- Behavior Treatment Plan with restrictive and/or intrusive techniques requiring review by the Behavior Treatment Plan Review Committee

Use of Psychotropic Medications TIP

Fill in the number of anti-psychotic and other psychotropic medications the individual is prescribed. See the codebook for further definition of 'anti-psychotic' and 'other psychotropic' and a list of the most common medications.

Number of Anti-Psychotic Medications

Psychiatric medications primarily used

Number of Other Psychotropic Medications

Includes anti-convulsant, anti-anxiety, anti-depressant, ADHD, Bi-Polar, OCD and other psychiatric medications prescribed.

to manage psychosis.

Notes

characters left: 4000

✓Spell Check

Record Added **Record Changed**

Save and Continue to Service Eligibility Criteria (DD) | Save

CANCEL

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Name: **Case #:** **Case:**

Date of Birth **Home Phone** **Current Admission**

Address **Primary Program:**
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12. Intake Assessment: Service Eligibility Criteria (DD)

Please verify Information

Service Eligibility Criteria for Individuals with Developmental Disabilities (Must Serve)

Strict adherence to the Mental Health Code definition of developmental disability:

☐ A. If applied to an individual older than 5 years, a severe, chronic condition that meets ALL of the following requirements:

☐ 1. Is attributable to a mental or physical impairment or a combination of mental and physical impairments.

Because disabilities that have not traditionally been considered developmental disabilities, e.g., muscular dystrophy, multiple sclerosis, can be consistent with the code definition, and though the DCH has not provided funding for them, applicants cannot be denied CMH services on the basis of having these disabilities. Most frequently, however, other special community agencies and supports will provide better service alternatives and should be pursued.

☐ 2. Is manifested before the individual is 22 years old

☐ 3. Is likely to continue indefinitely

☐ 4. Results in SUBSTANTIAL FUNCTIONAL LIMITATIONS in 3 or more of the following areas of major life activity:

- ☐ a. Self-care
- ☐ b. Receptive and expressive language
- ☐ c. Learning
- ☐ d. Mobility
- ☐ e. Self-Direction
- ☐ f. Capacity for independent living
- ☐ g. Economic self-sufficiency

Unable to define "substantial functional limitation" concretely, MCCMH prefers using three other means by which to make service eligibility decisions when the degree of functional limitation is far from clear. The individual can be considered to have a disability that results in "substantial functional impairment" if:

☐ 1) the individual has obtained SSI or SSD on the basis of a disability

-- OR --

☐ 2) school testing establishes that the individual is EMI or SMI and has an IQ of 69 or lower

-- OR --

☐ 3) a CMH psychologist confirms it through psychological testing

☐ 5. Reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of a lifelong or extended duration and are individually planned and coordinated

☐ B. If applied to a minor from birth to age 5, a substantial developmental delay or a specific congenital or acquired condition with a high probability of resulting in developmental disability as defined above if services are not provided

✓Spell Check

Record Added **Record Changed**

Save and Continue to Diagnosis | Save | CANCEL

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Name: **Case #:** **Case:**

Date of Birth **Home Phone** **Current Admission**

Address **Primary Program:**
Case Holder:

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13. Intake Assessment: Diagnosis

Please verify Information

	ICD-9	DSM-IV	Description	Status Date	Status
Pri				Use Current Date	
Sec				Use Current Date	
Ter				Use Current Date	

Substance Abuse Diagnoses

AXIS I

	ICD-9	DSM-IV	Description	Status Date	Status
Pri				Use Current Date	
	Specifier / Status Detail:				
Sec				Use Current Date	
	Specifier / Status Detail:				
Ter				Use Current Date	
	Specifier / Status Detail:				

AXIS II

	ICD-9	DSM-IV	Description	Status Date	Status
Pri				Use Current Date	
Sec				Use Current Date	
Ter				Use Current Date	

AXIS III

	ICD-9	DSM-IV	Description	Status Date	Status
Pri				Use Current Date	
Sec				Use Current Date	
Ter				Use Current Date	

AXIS IV

- ☐ Economic problems
- ☐ Problem accessing healthcare
- ☐ Educational problems
- ☐ Occupational problems
- ☐ Housing problems
- ☐ Problem with primary support group
- ☐ Problem related to social environment
- ☐ Problem related to interaction with legal system
- ☐ Other psychosocial and environmental problems
- ☐ Behavioral / Personality issues

AXIS V

Current GAF **Date**

Use Current Date

Show Functional Assessment Measure History

Diagnostic Formulation

characters left: 4096

Co-Occurring Consumer Quadrant

Co-Occurring Consumer Quadrant Comments

characters left: 1024

Additional Information / Help

Diagnosis Made By (Name/Credentials)

Diagnosis Effective Date

Use Current Date

History of Diagnosis lookup

Last Updated

Disability Designation

Developmental Disability

Yes No

Mental Illness

Yes No

SUD

No SUD

Not Evaluated for SUD

1 or more SUD Dx Codes active or in partial remission (use within past year)

1 or more SUD Dx Codes with all SUD Dx codes in full remission (no use for 1 year)

Results from screening suggest SUD

Individual received an assessment only, and was found to meet none of the disabilities listed above

Yes No

CAFAS Score

PECAFAS Score

DLA-20 Score

Strengths

characters left: 30000

Needs

characters left: 30000

Abilities

characters left: 30000

Preferences

characters left: 30000

✓Spell Check

Record Added

Record Changed

Save and Continue to Recommendations for Continued Treatment | Save

CANCEL

Back Home

Consumer Name	Case #	DOB	Home Phone	Status
Eligibility/Insurance Information				

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1. Basic Information
2. Medical Information
3. Health Conditions
4. Education & Employment
5. Corrections Related Status
6. Presenting Problems
7. Risk Assessment
8. Mental Status (MI/SED)
9. Psychiatric and Substance Abuse History(MI/SED)
10. Substance Abuse Chart(MI/SED)
11. DD Proxy Measures
12. Service Eligibility Criteria (DD)
13. Diagnosis
14. **Recommendations for Continued Treatment**
15. Send Copy to
16. Signatures

14. Annual Assessment: Recommendations for Continued Treatment

Please verify Information

Summary of Findings and Recommendations

An interpretive summary of findings that includes diagnostic formulation (sxs, functioning, hx), and summary of clinical and/or supports needs to be addressed by MCCMH services.

characters left: 30000

Transition/Discharge Planning

characters left: 30000

✓Spell Check

Record Added **Record Changed**

Save and Continue to Send Copy to | Save | CANCEL

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Name: **Case #:** **Case:**

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15. Intake Assessment: Send Copy to

Instructions:
Once this document has been signed, it will be copied and sent to all parties listed below. For all documents that are to be sent outside of your agency, please be sure you have a valid Authorization for Release of Information before adding this copy request.
- To notify staff of document completion, click on **Send to Staff**.
- To send a copy of this document to a location outside of your agency, click on **Send External Copy**.
- To share a copy of this document with another County / Affiliate click on **Send Copy to County / Affiliate**.

5 Document Copies

Send Copy To / Review By	Status
lookup clear	
lookup clear	
lookup clear	
Location: lookup clear **Contact Name:** **Purpose:**	
Location: lookup clear **Contact Name:** **Purpose:**	

Send to Staff Send External Copy

Record Added **Record Changed**

Save and Continue to Signatures | Save | CANCEL

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Name: **Case #:** **Case:**

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16. Intake Assessment: Signatures

Service Activity Logs

Staff:

Consumer:

If this is **not** the program providing the service, please use the LOOKUP button to select a new program

Date:
Begin:
End:
SAL Spans Midnight

Contact Type:
Attendance:
Place of Service:
Staff Type: Contract

IDDT

Authorization:

CPT Code: lookup clear

-

Please use the LOOKUP button to find an authorization and CPT code for the service provided

Was physician on site? (Medicare)
Yes No

Physician on Site: lookup clear

Electronic Signatures

Staff Signature Required By lookup

Supervisor Signature lookup clear

Physician Signature lookup clear

Record Added **Record Changed**

Save CANCEL

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