Case Management Comprehensive Assessment

Section A: Consumer Information

Consumer

Name: (First, M.I., Last)	Medicaid State ID#	Date Of Birth:
Current Address:		
County of Residence:	County of Legal Settlement:	
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Assessor

Name:	Title:
Agency:	
Address:	
Phone:	E-Mail:
Signature	Date

Type of Assessment

☐ Initial
☐ Annual
☐ Special
☐ Demographic Change Only Date:
☐ Discharge Date: Reason:

Basis of Case Management Eligibility

☐ CMI ☐ MR ☐ DD ☐ BI Waiver ☐ Elderly Waiver ☐ CMH Waiver ☐ Habilitation ☐ MFP

VERIFICATION OF HCBS WAIVER CONSUMER CHOICE: ***Complete this section for consumers applying for HCBS Brain Injury Waiver, Children's Mental Health Waiver, Intellectual Disability Waiver.***

Home- and Community-Based Services (HCBS)

My right to choose a Home- and Community-Based program has been explained to me. I have been advised that I may choose: (1) Home- and Community-Based Services or (2) Medical Institutional Services.

I choose: ☐ HCBS ☐ Medical Institutional Services

Signature of Consumer or Guardian or Durable Power of Attorney for Health Care	Date

Case Management Comprehensive Assessment

Consumer Name:
Interdisciplinary team members consulted (including consumer):

Name	Title (if applicable)	Relationship to Consumer

Additional records reviewed:

Consumer Demographics

Gender: ☐ Female ☐ Male

Language:

	Yes	No
Speaks English	☐	☐
Understands English	☐	☐
Needs interpreter services	☐	☐
Comments:		

Monthly Income: (Please check all that apply)

Source	Amount
☐ SSI	$
☐ SSDI	$
☐ Employment	$
☐ Other (specify):	$
Comments:	

Court Involvement:

☐ Involuntary Commitment
☐ Probation or Parole
☐ Child in Need of Assistance (CINA)
☐ Child Protection
☐ Delinquency
☐ Foster Care
☐ Other (Identify)
☐ None
Comments:

Case Management Comprehensive Assessment

Consumer Name:

Legal decision maker: (Please check all that apply)

☐ None ☐ Guardian ☐ Attorney-in-fact ☐ Other (Specify):

Name: (First, M.I., Last)		
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Co-Decision Maker (if applicable):

☐ Guardian ☐ Attorney-in-fact ☐ Other (Specify):

Name: (First, M.I., Last)		
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Financial Decision Maker: (e.g. Conservator or Attorney-in-fact) No ☐ Yes ☐(complete below)

Name: (First, M.I., Last)		
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Payee: No ☐ Yes ☐(complete below)

Name: (First, M.I., Last)		
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Emergency Contacts:

Primary Contact

Name: (First, M.I., Last)		Relationship:
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Case Management Comprehensive Assessment

Consumer Name:
Secondary Contact (if applicable):

Name: (First, M.I., Last)		Relationship:
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail:		

Complete This Section For Adults (Age 18 and Over)

Veteran: ☐ Yes ☐ No

Marital Status:
- ☐ Never Married
- ☐ Married Spouse's Name:
- ☐ Divorced
- ☐ Legally Separated
- ☐ Widowed
- ☐ Unknown or Other – Specify

Comments:

Complete This Section For Children (Age 17 and Under)

With whom does the child live?
(*If the child currently lives in a institutional setting, please make note in the comments section below.*)

What are the child's parent's names?

Parents marital status: ☐ Married ☐ Divorced ☐ Never married

If the parent's are not living together, what is the non-custodial parent's name and address?

Name:
Street:
City, State, Zip:

Parent's contact information (if different from the child's):

Home Phone:
Work Phone:
Cell Phone:
E-Mail:

Are there siblings in the home? ☐ Yes ☐ No

Are any siblings receiving waiver services? ☐ Yes ☐ No

Are there any individuals who are not supposed to have contact with the child? ☐ Yes ☐ No

If yes, specify:

Other Comments:

Case Management Comprehensive Assessment

Consumer Name:

Medical Information

Diagnoses:

Medical:

Diagnosis	
Name and credential of professional making diagnosis:	Date of diagnosis:
Comments:	

Mental Health (DSM-IV-TR)

Axis 1:		
Axis 2:		
Axis 3:		
Axis 4:		
Axis 5:		
Name and credential of professional making diagnosis:		Date of diagnosis:
Comments:		

Complete this section for consumers applying for or receiving HCBS Intellectual Disability Waiver.

List the most current IQ score, or if the IQ isn't listed, give the consumer's level of functioning within the range of mental retardation (mild, moderate, severe, profound):

IQ: Range: Date of Evaluation:

Complete this section for consumers applying for or receiving HCBS Brain Injury Waiver.

Diagnosis: Date Injury Occurred:

Health Care Provider Information:

Who is your regular doctor? ☐ None

Name	Address	Phone
Date of last visit (if known):	Reason:	

Who is your regular dentist? ☐ None

Name	Address	Phone
Date of last visit (if known):	Reason:	

Are you seeing any other doctors, such as a psychiatrist, or specialists of any kind?

☐ Yes (list below) ☐ No ☐ Don't know

Name	Specialty	Address	Phone

Case Management Comprehensive Assessment

Section B: Medical and Physical Health

Health Conditions

B1. Overall, how would you rate your physical health?

☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ No Response
Comments:				

B2. Do you have any health problems that require assistance to manage?

☐ Cardiac ☐ Skin Related ☐ G.I. Disorders ☐ Urinary Tract ☐ Weight problems ☐ Evidence of communicable disease ☐ Other – Specify ☐ None
How do they affect you and how long have you had them?
Comments:

B3. Any respiratory problems that require assistance to manage?

☐ Ventilator ☐ Oxygen ☐ Suctioning ☐ Tracheotomy ☐ Cardiorespiratory monitor ☐ Chest physiotherapy ☐ Nebulizer treatment ☐ Other – Specify ☐ None
How do they affect you and how long have you had them?
Comments:

B4. Do you regularly receive any of the following medical treatments?

			Days per week	**Hours per day**
Nursing	☐ no	☐ yes		
Physical Therapy	☐ no	☐ yes		
Occupational Therapy	☐ no	☐ yes		
Speech Therapy	☐ no	☐ yes		
Supervision for Safety	☐ no	☐ yes		
Diabetes Education	☐ no	☐ yes		
Dialysis	☐ no	☐ yes		
Respiratory Treatment	☐ no	☐ yes		
Catheter Care	☐ no	☐ yes		
Colostomy Care	☐ no	☐ yes		
Nasogastric Tube Care	☐ no	☐ yes		
Other	☐ no	☐ yes		

Consumer Name:

B5. Hearing

- ☐ No hearing impairment.
- ☐ Hearing impairment, but managed through assistive devices
- ☐ Hearing difficulty at level of conversation.
- ☐ Hears only very loud sounds.
- ☐ No useful hearing.
- ☐ Not determined.

Comments:

B6. Vision

- ☐ Has no impairment of vision.
- ☐ Vision impairment, but managed through assistive devices
- ☐ Has difficulty seeing at level of print (far-sighted).
- ☐ Has difficulty seeing obstacles in environment (near-sighted).
- ☐ Has no useful vision.
- ☐ Not determined.

Comments:

B7. Speech/Communication

- ☐ Communicates independently or impairment has been compensated to function independently.
- ☐ Communicates with difficulty but can be understood.
- ☐ Communicates with sign language, symbol board, written messages, gestures or an interpreter.
- ☐ Communicates inappropriate content, makes garbled sounds, or displays echolalia.
- ☐ Does not communicate.

Comments:

B8. Sensory Perception (e.g. – taste, smell, tactile, spatial)

- ☐ No impairment
- ☐ Impaired – Specify

Comments:

B9. Cognitive Status

- ☐ Alert and fully oriented
- ☐ Alert and oriented with significant alteration on self-concept/mood
- ☐ Generally oriented through use of assistive techniques
- ☐ Cognitive deficits (e.g. orientation, attention/concentration, perception, memory, reasoning)
- ☐ Exhibits mental status changes consistent with psychiatric disorder
- ☐ Comatose, but responsive
- ☐ Comatose, but unresponsive
- ☐ Other – Specify

Comments:

B10. Musculoskelatal/Fine or Gross Motor Skills

- ☐ No Impairment of Musculoskelatal/Fine or Gross Motor Skills
- ☐ Impaired muscle tone
- ☐ Contractures
- ☐ Scoliosis

Paralysis: ☐ Hemiplegia ☐ Paraplegia ☐ Quadriplegia ☐ Other (Specify)

Comments:

Case Management Comprehensive Assessment

Consumer Name:

Complete This Section For Adults (Age 18 and Over)

B11. Do you have someone who could stay with you for a while if you were sick or needed help?
☐ Yes (Complete below) ☐ No
Name: Relationship:
Address:
City, State, Zip code:
Phone:

B12. Is there anybody you would **not** want to be involved with your care if you were sick or needed help?
☐ Yes (Complete below) ☐ No
Name: Relationship:

HEALTH CONDITIONS RISK FACTORS	YES	NO
R1. Has the consumer had a seizure in the past year?	☐	☐
R2. Does the consumer have a diagnosis of any other serious medical conditions or other serious health concerns (i.e., diabetes, cerebral palsy, heart condition, etc.)? If yes, list all conditions/concerns:	☐	☐
R3. Does the consumer have any life threatening allergies (such as peanuts, bee stings, or shellfish)?	☐	☐
R4. Is the consumer in need of a primary health care provider (or the provider's contact information is unknown)?	☐	☐
R5. Is the consumer in need of a dentist (or dentist's contact information is unknown)?	☐	☐
R6. Is the consumer in need of a specialist (or the specialist's contact information is unknown)?	☐	☐
R7. Has the consumer had difficulty making, keeping, or following through with appointments in the last year?	☐	☐
R8. In the past year, has the consumer gone to a hospital emergency room? If yes, how many times? Why?	☐	☐
R9. In the past year, has the consumer stayed overnight or longer in a hospital? If yes, how many times? Why?	☐	☐
R10. Is the consumer in need of someone to help if he or she was sick or injured?	☐	☐
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:	

Case Management Comprehensive Assessment

Consumer Name:

Medication Use

B13. Are you currently taking any *prescription* medication? ☐ Yes (complete below) ☐ No

Medication Name	Dosage	Frequency	Purpose
Comments:			

B14. Are you currently taking any *over-the-counter* medications on a regular basis (pain relievers, vitamins, laxatives, etc.)? ☐ Yes (complete below) ☐ No

Medication Name	Dosage	Frequency	Purpose
Comments:			

Consumer Name:

Complete this section only if the consumer is taking medications.

B15. Are any of your medications kept in a special place, like a locked container or the refrigerator?
☐ Yes ☐ No
Comments:

B16. What pharmacy do you use?

B17. How do you remember to take your medications? (Check all that apply.)
☐ By following directions ☐ Calendar ☐ RN Set-up
☐ Caregiver gives them ☐ Bubble wrap/Blister Pack ☐ Pill Minder
☐ Medpass Machine ☐ Egg Carton, envelopes ☐ Other:
Comments:

B18. How well do you self-administer medication?
☐ With no help or supervision
☐ With some help or occasional supervision
☐ With a lot of help or constant supervision
☐ Unable to administer own medications/caregiver gives them
Comments:

MEDICATION ERROR RISK FACTORS **3 = Frequently 2 = Sometimes 1 = Rarely 0 = Never**	**YES**		**NO**	
	3	**2**	**1**	**0**
R11. Has the consumer had problems with not taking or not receiving medications on time?	☐	☐	☐	☐
R12. Has the consumer had problems with taking or being given the incorrect number of medications?	☐	☐	☐	☐
R13. Has the consumer had problems with medications not being refilled on time?	☐	☐	☐	☐
R14. Have there been issues with medications not being re-evaluated timely?	☐	☐	☐	☐
R15. Has the consumer had significant side effects from medications?	☐	☐	☐	☐
R16. Has the consumer had significant medication changes in the past year?	☐	☐	☐	☐
R17. Has the consumer refused or spit out medications?	☐	☐	☐	☐
R18. Have there been problems with drug interactions?	☐	☐	☐	☐
R19. Has the consumer experienced health problems because of missing/refusing medications?	☐	☐	☐	☐
R20. Has the consumer misused prescription or over-the-counter medications (i.e., taken too many at once)?	☐	☐	☐	☐
R21. Has the consumer taken another person's prescription medications?	☐	☐	☐	☐
R22. Has the consumer used out-dated medications?	☐	☐	☐	☐
R23. Has the consumer used multiple pharmacies or multiple physicians in the past year?	☐	☐	☐	☐
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Case Management Comprehensive Assessment

Consumer Name:

Assistive Devices/Special Equipment

B19. Do you use (or need) any of the following special equipment or aids? None ☐

(If a consumer doesn't have an item but needs it, mark the "Needs" box)

Uses	Needs		Uses	Needs	
☐	☐	Dentures	☐	☐	Hospital bed
☐	☐	Cane	☐	☐	Medical phone alert
☐	☐	Walker	☐	☐	Supplies, e.g. Incontinence pads
☐	☐	Wheelchair (manual, electric)	☐	☐	Bedside commode
☐	☐	Brace (leg, back)	☐	☐	Bathing equipment
☐	☐	Helmet	☐	☐	Lift chair
☐	☐	Communication Devices	☐	☐	Transfer equipment
☐	☐	Hearing aid	☐	☐	Adaptive eating equipment
☐	☐	Glasses/contact lenses	☐	☐	Harness/gait belt
☐	☐	Weighted blankets or vest	☐	☐	Other (Specify):
Comments:					

ASSISTIVE DEVICES RISK FACTORS **3 = Frequently 2 = Sometimes 1 = Rarely 0 = Never**	**YES**		**NO**	
	3	**2**	**1**	**0**
R24. Is the consumer in need of assistance with adaptive equipment (need it purchased, need training, need repairs, etc.)?	☐	☐	☐	☐
R25. Would a power outage interfere with the consumer's necessary adaptive equipment?	☐	☐	☐	☐
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Nutrition

B20. How is your appetite?

☐ Good ☐ Fair ☐ Poor
Comments:

B21. Has there been an unexplained weight loss or weight gain in the past year?

☐ Yes (specify in comments) ☐ No
Comments:

B22. Are there health concerns related to your nutrition?

☐ Yes (specify in comments) ☐ No
Comments:

Consumer Name:

B23. Do you have a diagnosed eating disorder (such as overeating, purging, hoarding food)?

☐ Yes (specify in comments)
☐ No

ASSESSOR: If no, does the consumer's behavior indicate a possible eating disorder or suggest the need for further evaluation?

☐ Yes (specify in comments)
☐ No

Comments:

B24. Do you have any problems that make it difficult to eat? ☐ Yes (complete below) ☐ No

☐ Dental problems	☐ Can't eat certain foods
☐ Swallowing problems	☐ Problem with gag reflex
☐ Texture Aversions	☐ Sensitive stomach/nausea
☐ Taste problems	☐ Tube feeding (some or all of the time)
☐ Any other eating problems? (Describe)	
Comments:	

B25. Are you on a special diet: ☐ Yes (complete below) No ☐

☐ Low salt	☐ Calorie supplement
☐ Low fat	☐ Gluten Free
☐ Low sugar	☐ Milk/lactose free
☐ Weight Loss	☐ Altered Consistency
☐ Other special diet? (Describe)	
Comments:	

NUTRITION RISK FACTORS **3 = Frequently 2 = Sometimes 1 = Rarely 0 = Never**	**YES**		**NO**	
	3	**2**	**1**	**0**
R26. Is the consumer at risk of choking or other problems when eating?	☐	☐	☐	☐
R27. Is the consumer's health at risk due to poor nutrition (e.g.- eating disorder, refusal to eat, inability to afford nutritious food, etc.)?	☐	☐	☐	☐
R28. Is the consumer (or the caretaker) ever non-compliant with the prescribed diet?	☐	☐	☐	☐
R29. Would the consumer's health be at risk if his or her diet is not strictly followed?	☐	☐	☐	☐
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Case Management Comprehensive Assessment

Consumer Name:

Daily Living Skills

B26. Daily Living Skills

Activity	Independent	Supervision or Verbal Prompts/Cueing	Physical Assistance	Total Dependence	Frequency	
					Daily	Intermittent
a. Eating	☐	☐	☐	☐	☐	☐
b. Grooming & personal hygiene	☐	☐	☐	☐	☐	☐
c. Bathing	☐	☐	☐	☐	☐	☐
d. Dressing	☐	☐	☐	☐	☐	☐
e. Mobility in bed	☐	☐	☐	☐	☐	☐
f. Transferring	☐	☐	☐	☐	☐	☐
g. Walking	☐	☐	☐	☐	☐	☐
h. Stair climbing	☐	☐	☐	☐	☐	☐
i. Mobility with wheelchair	☐	☐	☐	☐	☐	☐
Comments (note use of assistive devices or adaptive equipment needed to demonstrate skill):						

B27. Toilet Use

☐ Continent – Bowel and bladder
☐ Continent with verbal or physical prompts
☐ Continent except for specified periods of time (e.g. enuresis)
☐ Incontinent – bladder
☐ Incontinent – bowel
☐ Catheter or -ostomy (e.g. suprapubic catheter, colostomy, ileostomy)
☐ Inappropriate toileting habits (e.g. fails to close door, use toilet paper, or wash hands, etc.)

Comments**:**

DAILY LIVING SKILLS RISK FACTORS 3 = Frequently 2 = Sometimes 1 = Rarely 0 = Never	YES		NO	
	3	2	1	0
R30. Is the consumer's health at risk due to poor hygiene?	☐	☐	☐	☐
R31. Is the consumer at risk for falling? In the past year has the consumer fractured a bone? If yes, how did this occur?	☐	☐	☐	☐
R32. Is the consumer at risk of being dropped or injured during transfer?	☐	☐	☐	☐
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Case Management Comprehensive Assessment

Consumer Name:

Consumer Needs, Wants, and Desired Results Related to Medical and Physical Health
What are your strengths and abilities related to your medical and physical health? *ASSESSOR*: List any other strengths and abilities not mentioned by the consumer or guardian: Do you have any other needs related to your medical and physical health that haven't been addressed above? *ASSESSOR*: List any other needs related to medical and physical health not mentioned by the consumer or guardian. Do you have any wants related to your medical and physical health? What are your desired results related to your medical and physical health?

Case Management Comprehensive Assessment

Section C: Mental Health, Behavioral & Substance Use

Emotional and Mental Health

C1. Have you ever been diagnosed with a mental illness?

☐ Yes ☐ No
If yes, what is it?

C2. Have you received mental health services in the past?

☐ Yes ☐ No
If yes, describe:

C3. Are you currently receiving any mental health services or counseling?

☐ Yes (If yes, complete below) ☐ No	
Provider Name and Address	**Comments**

C4. Emotional Assessment. How have you been feeling during the past month?

	Yes	No
Are you satisfied with your life today?	☐	☐
Have you been depressed or very unhappy?	☐	☐
Have you been feeling like you have too much energy or can't stop being busy?	☐	☐
Have you been anxious?	☐	☐
Have you had mood swings?	☐	☐
Have you had difficulty sleeping?	☐	☐
Have you felt unmotivated or felt a lack of energy?	☐	☐
Have you felt lonely or isolated?	☐	☐
Comments:		

C5. *ASSESSOR:* Other mental health symptoms.

	Yes	No
Has the consumer had hallucinations (seen or heard things that weren't really there)?	☐	☐
Has the consumer reported feelings of paranoia?	☐	☐
Has the consumer had delusions (irrational thoughts that weren't true)?	☐	☐
Comments:		

Consumer Name:

Complete This Section For Children (Age 17 and Under)

C6. Has the child experienced difficulty in interpersonal relationships within the family?
☐ Yes ☐ No
Comments:

C7. Does the parent/guardian exhibit mental health related concerns?
☐ Yes ☐ No
If yes, is he/she currently receiving treatment and following through with treatment?
☐ Yes ☐ No
Comments:

Behavioral

C8. *ASSESSOR:* Behavioral Assessment.

Behavioral Issue	**Does not exhibit**	**Has been modified to socially acceptable levels**	**May require verbal or physical intervention**
Has episodes of disorientation, being withdrawn, or similar behaviors	☐	☐	☐
Noncompliance with rules or directions	☐	☐	☐
Physically abusive to self	☐	☐	☐
Verbally aggressive toward others	☐	☐	☐
Physically aggressive toward others	☐	☐	☐
Exhibits disruptive behavior (e.g. arguing, shouting, etc.)	☐	☐	☐
Exhibits destructive behavior (e.g. destroying property, burning, etc.)	☐	☐	☐
Exhibits stereotypical, repetitive behavior (e.g. rocking, twirling fingers or objects, etc.)	☐	☐	☐
Obsessive/compulsive behavior	☐	☐	☐
Antisocial behavior (e.g. lying, stealing, inappropriate touching, etc.)	☐	☐	☐
Wanders into private areas, or habitually elopes	☐	☐	☐
Acts in a sexually inappropriate or aggressive manner	☐	☐	☐
Engages in excessive liquid consumption	☐	☐	☐
Comments:			

Alcohol/Tobacco/Substance Use

C9. Do you drink any alcoholic beverages?

☐ Yes ☐ No
If yes, on average, counting beer, wine, and other alcoholic beverages, how many drinks do you have each day?
Comments:

C10. Do you smoke or use tobacco?

☐ Yes ☐ No
If yes, how much and how often? *(frequency per day)*
Comments:

C11. Has tobacco use caused you any problems?

☐ Yes ☐ No
If yes, please describe:
Comments:

Consumer Name:

C12. Do you use any other illegal substances such as marijuana, cocaine, or amphetamines?

☐ Yes ☐ No
If yes, specify:
Comments:

C13. Are the people who are involved in your life (spouse, parents/guardian, friends, etc.) concerned about your alcohol/tobacco/substance use?

☐ Yes ☐ No
If yes, explain:
Comments:

C14. Do you live with or spend time with a person that has alcohol/substance abuse concerns, including misuse of prescription medication? (For children, this includes the parent/guardian)

☐ Yes ☐ No
If yes, specify:
Comments:

C15. *ASSESSOR:* Does the person need education about substance use/abuse?

☐ Yes ☐ No
If yes, please describe:
Comments:

C16. *ASSESSOR:* Are you concerned about the person's alcohol/tobacco/substance use?

☐ Yes ☐ No
Comments:

MENTAL HEALTH/BEHAVIORAL/SUBSTANCE USE RISK FACTORS **3 = Within the last 6 months 2 = Within the last year 1 = more than 1 year ago 0 = Never**	**YES**		**NO**	
	3	**2**	**1**	**0**
R33. Has the consumer ingested foreign objects or been diagnosed with PICA?	☐	☐	☐	☐
R34. Has alcohol use caused the consumer any problems?	☐	☐	☐	☐
R35. Has substance use caused the consumer any problems?	☐	☐	☐	☐
R36. Has the consumer engaged in self-injurious behaviors?	☐	☐	☐	☐
R37. Has the consumer left or attempted to leave home or other supervised activities without permission, or when it would be unsafe to do so?	☐	☐	☐	☐
R38. Has the consumer been aggressive toward others?	☐	☐	☐	☐
R39. Has the consumer used weapons or objects to hurt self or others? *(If 3 or 2, assure that referral has been made to a qualified mental health professional)*	☐	☐	☐	☐
R40. Has the consumer threatened suicide or made suicidal gestures? *(If 3 or 2, assure that referral has been made to a qualified mental health professional)*	☐	☐	☐	☐

Case Management Comprehensive Assessment

Consumer Name:

MENTAL HEALTH/BEHAVIORAL/SUBSTANCE USE RISK FACTORS 3 = Within the last 6 months 2 = Within the last year 1 = more than 1 year ago 0 = Never	YES		NO	
	3	2	1	0
R41. Has the consumer attempted suicide? *(If 3 or 2, assure that referral has been made to a qualified mental health professional)*	☐	☐	☐	☐
R42. Has the consumer engaged in criminal behavior?	☐	☐	☐	☐
R43. Has the consumer had a significant life change or event occur?	☐	☐	☐	☐
R44. Does the consumer have a history of other life-threatening behaviors? Specify:	☐	☐	☐	☐
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

C17. *ASSESSOR:* In your opinion would this person benefit from a:

☐ Mental health referral
☐ Mental health evaluation
☐ Substance abuse referral
☐ Substance abuse evaluation
☐ Referral for a behavioral assessment
☐ Other (specify):
☐ None
Comments:

Consumer Needs, Wants, and Desired Results Related to Mental Health, Behavior, or Substance Abuse
What are your strengths and abilities related to mental health, behavior, or substance abuse? *ASSESSOR*: List any other strengths and abilities not mentioned by the consumer or guardian: Do you have any other needs related to mental health, behavior, or substance abuse that haven't been addressed above? *ASSESSOR*: List any other needs related to mental health, behavior, or substance abuse not mentioned by the consumer or guardian. Do you have any wants related to mental health, behavior, or substance abuse? What are your desired results related to mental health, behavior, or substance abuse?

Case Management Comprehensive Assessment

Section D: Housing and Environment

D1. What is your current housing type?

☐ Own Home (includes parent/guardian's home for children) ☐ Friend/Relative Home ☐ Foster Care ☐ RB-SCL ☐ RCF ☐ RCF-PMI ☐ RCF-MR ☐ ICF-MR ☐ ICF/Nursing Facility ☐ MHI ☐ Skilled Nursing Facility ☐ Homeless ☐ Jail ☐ Other (specify):
Comments:

D2. What is your current living arrangement?

☐ Living Alone ☐ Living with Family/Friend ☐ Living with Spouse/Significant Other ☐ Living with Parents ☐ Living in Congregate Setting ☐ Other (specify):
Comments:

D3. Would you like to continue to live where you do now, or is there somewhere else you would prefer to live?

☐ Continue to live here ☐ Don't know ☐ Prefer to live elsewhere (Specify and briefly describe the barriers, if any:)
Comments:

D4. Is there someone who regularly helps you care for your home or yourself, or who regularly helps with errands or other things? (For children, do NOT include the parent/guardian, but do include others who assist the parent/guardian.)

☐ Yes ☐ No
If yes, how often? Caregiver's Name:

D5. Do you have any home modifications? Check all that apply:

☐ Safe Room	☐ Shatter Proof Windows
☐ Door/Window Alarms	☐ Fenced yard
☐ Wheelchair Ramp	☐ None
☐ Other (specify):	
Are any home modifications needed? ☐ Yes (specify): ☐ No	

Consumer Name:

Complete This Section For Children (Age 17 and Under)
(*If the child is currently living in a institutional setting, skip questions D6 through D9 and not the living situation in the comment section below.*)

D6. Does the family with whom the child is residing have a stable housing situation? ☐ Yes ☐ No
If not, does the family need assistance in identifying additional resources?

D7. Does the parent/guardian have a physical disability that impairs his/her ability to meet the child's needs? ☐ Yes ☐ No
If yes, what have the parents done to ensure the child's needs are being met consistently?

D8. Does the family have adequate financial resources? ☐ Yes ☐ No
If not, does the family need assistance in identifying additional resources?

D9. Does the child have his or her own money? ☐ Yes ☐ No
Where does it come from?

Other Comments:

Independent Living Skills

D10. How well can you prepare meals for yourself? (Meals may include sandwiches, pre-cooked meals and TV dinners.)

☐ Need no help or supervision
☐ Need some help or occasional supervision
☐ Need a lot of help or constant supervision
☐ Can't do it at all

Comments:

D11. Do you know your telephone number?

☐ Yes	☐ No	☐ N/A

D12. Do you know your address?

☐ Yes	☐ No	☐ N/A

D13. *ASSESSOR*: Can this consumer be left without supervision?

☐ Yes	☐ No	☐ N/A

If yes, for how long?

D14. How well are you able to answer the telephone?

☐ Need no help or supervision
☐ Need some help or occasional supervision
☐ Need a lot of help or constant supervision
☐ Can't do it at all

Comments:

D15. How well are you able to make a telephone call?

☐ Need no help or supervision
☐ Need some help or occasional supervision
☐ Need a lot of help or constant supervision
☐ Can't do it at all

Comments:

Consumer Name:

D16. How well can you handle your own money? (understands use of money, can pay for things, can pay bills, can balance the checkbook, etc. as appropriate for age)

- ☐ Need no help or supervision
- ☐ Need some help or occasional supervision
- ☐ Need a lot of help or constant supervision
- ☐ Can't do it at all

Comments:

D17. How well can you manage shopping for food and other things you need?

- ☐ Need no help or supervision
- ☐ Need some help or occasional supervision
- ☐ Need a lot of help or constant supervision
- ☐ Can't do it at all

Comments:

Complete This Section For Adults (Age 18 and Over)

D18. How well can you manage to do light housekeeping, like dusting or sweeping?

- ☐ Need no help or supervision
- ☐ Need some help or occasional supervision
- ☐ Need a lot of help or constant supervision
- ☐ Can't do it at all

Comments:

D19. How well can you do heavy housekeeping, like yard work, or emptying the garbage?

- ☐ Need no help or supervision
- ☐ Need some help or occasional supervision
- ☐ Need a lot of help or constant supervision
- ☐ Can't do it at all

Comments:

D20. How well can you do your own laundry, including putting clothes in the washer or dryer, starting and stopping the machine, and drying the clothes?

- ☐ Need no help or supervision
- ☐ Need some help or occasional supervision
- ☐ Need a lot of help or constant supervision
- ☐ Can't do it at all

Comments:

D21. *ASSESSOR:* Does the consumer have deficits that pose a threat to his/her ability to live in the community?

☐Yes ☐No ☐Unsure

Case Management Comprehensive Assessment

Consumer Name:

Complete This Section For Children (Age 17 and Under)

D22. Does the child do chores? ☐ Yes ☐ No
If yes, what are they?

How independent is the child in completing chores?
☐ Need no help or supervision
☐ Need some help or occasional supervision
☐ Need a lot of help or constant supervision
☐ Can't do it at all
Comments:

HOUSING AND ENVIRONMENTAL SAFETY RISK FACTORS	Yes	No
R45. Would this consumer's health be at risk if a paid provider or natural support person did not show up to provide scheduled services?	☐	☐
R46. Is the consumer at risk at home because of any of these conditions:		
structural damage	☐	☐
barriers to accessibility (steps, etc.)	☐	☐
electrical hazards	☐	☐
signs of careless smoking	☐	☐
insects or pests	☐	☐
poor lighting	☐	☐
insufficient water or no hot water	☐	☐
insufficient heat	☐	☐
fire hazards	☐	☐
tripping hazards	☐	☐
unsanitary conditions	☐	☐
R47. Does the consumer need to be supervised at all times?	☐	☐
R48. Is the consumer without means of communication (no phone or PERS)?	☐	☐

For the following items use: 3 = Frequently 2 = Sometimes 1 = Rarely 0 = Never	3	2	1	0
R49. Is the consumer unable to respond to emergencies independently? If consumer is never left alone, mark not applicable: ☐ N/A	☐	☐	☐	☐
R50. Is the consumer physically stronger than any of his/her caregivers?	☐	☐	☐	☐
R51. Does the consumer lack awareness of dangerous/emergency situations?	☐	☐	☐	☐
R52. Does the consumer put him/herself in danger due to careless or risky behaviors (careless smoking, leaving doors unlocked, etc.)?	☐	☐	☐	☐
R53. Is the consumer isolated (lack of transportation, lack of social network)?	☐	☐	☐	☐
R54. Is the consumer's neighborhood unsafe (high risk of crime, etc.)?	☐	☐	☐	☐
R55. Is the consumer at risk in the community due to unsafe behaviors?	☐	☐	☐	☐
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Case Management Comprehensive Assessment

Consumer Name:

Abuse/Neglect

D23. *ASSESSOR*: Does the consumer have a history of incidents that have resulted in injury or threat of injury in the past year? (Consult incident reports as necessary)

☐ Yes ☐ No
If yes, are the causes of the incidents covered in the Crisis Intervention Plan? ☐ Yes ☐ No (specify why not):

ABUSE/NEGLECT RISK FACTORS **3 = Within the last 6 months 2 = Within the last year 1 = more than 1 year ago 0 = Never**	**YES**		**NO**	
	3	**2**	**1**	**0**
R56. Has the consumer been physically abused?	☐	☐	☐	☐
R57. Has the consumer been sexually abused?	☐	☐	☐	☐
R58. Has the consumer been emotionally or psychologically abused?	☐	☐	☐	☐
R59. Is there evidence of neglect to the consumer by a caregiver?	☐	☐	☐	☐
R60. Is there evidence of neglect by the consumer (self neglect)?	☐	☐	☐	☐
R61. Has the consumer been denied basic necessities?	☐	☐	☐	☐
R62. Has the consumer witnessed abuse or neglect of another person, including domestic violence?	☐	☐	☐	☐
R63. Would the consumer be an "easy target"?	☐		☐	
Comment on any risk factors marked as "Yes" and address the issue in the Crisis Intervention Plan. Comments:	No. of risks:			

Consumer Needs, Wants, and Desired Results Related to Housing and Environment
What are your strengths and abilities related to your housing and environment? *ASSESSOR*: List any other strengths and abilities not mentioned by the consumer or guardian: Do you have any other needs related to your housing and environment that haven't been addressed above? *ASSESSOR*: List any other needs related to housing and environment not mentioned by the consumer or guardian. Do you have any wants related to your housing and environment? What are your desired results related to your housing and environment?

Case Management Comprehensive Assessment

Section E: Social

E1. Do you feel you need help with social skills?

☐ Yes
☐ No

Comments:

E2. What is a typical day like for you? *(or ask:* What do you usually do, starting from the morning?)

What, if anything, would you change about your typical day?

Comments:

E3. What activities or things do you enjoy doing?

Are there activities you enjoy that you would like to do more frequently?
☐ Yes
☐ No
If yes, what are they?

Is anything needed to support or help you to do these activities?
☐ Yes
☐ No
If yes, what?

Comments:

E4. If you choose to practice a religion, are able to attend as often as desired?

☐ Yes (Specify where):
☐ No
☐ N/A

Comments:

E5. *ASSESSOR*: Does the consumer have knowledge or self-concept of his or her own sexuality appropriate to age level?

☐ Yes
☐ No

Comments:

E6. Do you communicate with friends, relatives, or others (not including paid helpers) as often as you would want?

☐ Yes
☐ No

By what means (phone, email, etc)? How Often?

Comments:

Consumer Name:

Complete This Section For Adults (Age 18 and Over)

E7. Do you spend time with others who do not live with you as often as you would want?
☐ Yes ☐ No
Comments:

E8. Do you have someone to confide in when you have a problem?
☐ Yes ☐ No
If yes, specify name and relationship:

Complete This Section For Children (Age 17 and Under)

E9. Who are your friends?
E10. What do you like to do with them?
E11. Where do you see your friends?
E12. Do you and your parents agree on your choice of friends?
☐ Yes ☐ No
If no, why not?

Consumer Needs, Wants, and Desired Results Related to Social Functioning

What are your strengths and abilities related to your social functioning?

ASSESSOR: List any other strengths and abilities not mentioned by the consumer or guardian:

Do you have any other needs related to your social functioning that haven't been addressed above?

ASSESSOR: List any other needs related to social functioning not mentioned by the consumer or guardian.

Do you have any wants related to your social functioning?

What are your desired results related to your social functioning?

Case Management Comprehensive Assessment

Section F: Transportation

F1. Do you need help with transportation?

☐ Yes ☐ No
If yes, when and where:

F2. How do you get to the places you want to go? (Check all that apply).

☐ Walk ☐ Bicycle ☐ Drive ☐ Take a bus or taxi ☐ Friend or family member drives ☐ Staff/Provider ☐ Other:
Comments:

F3. How well are you able to use public transportation or drive to places beyond walking distance?

☐ Need no help or supervision ☐ Need some help or occasional supervision ☐ Need a lot of help or constant supervision ☐ Not Available ☐ Can't do it at all
Comments:

F4. Are there any vehicle modifications needed?

☐ Yes ☐ No If yes, specify:
Comments:

Consumer Needs, Wants, and Desired Results Related to Transportation
What are your strengths and abilities related to transportation? *ASSESSOR*: List any other strengths and abilities not mentioned by the consumer or guardian: Do you have any other needs related to transportation that haven't been addressed above? *ASSESSOR*: List any other needs related to transportation not mentioned by the consumer or guardian. Do you have any wants related to transportation? What are your desired results related to transportation?

Case Management Comprehensive Assessment

Section G: Education

G1. Are you currently in school?

☐ Yes ☐ No If yes, specify where: If no, and the consumer is a child, why not?
Comments:

G2. If in school, are you involved in any extra-curricular activities?

☐ Yes ☐ No ☐ N/A If yes, specify:
Comments:

G3. *ASSESSOR:* Is the consumer able to:

	Yes	No	Comments
Read?	☐	☐	
Write?	☐	☐	
Sign his/her name?	☐	☐	

G4. Are you interested in furthering your education?

☐ Yes ☐ No If yes, what area do you want to further your education in?
Comments:

G5. Do you need assistance or support in gaining access to educational services?

☐ Yes ☐ No If yes, please specify what type of assistance is needed:
Comments:

G6. *ASSESSOR:* Does the consumer have any intellectual or cognitive difficulties?

☐ No intellectual problems
☐ Has difficulties but is able to function with minimal assistance or adaptive devices
☐ Has intellectual problems requiring verbal or physical assistance (check all that apply): ☐ Difficulty with or unable to tell time ☐ Does not know survival words or signs ☐ Problems with reading ☐ Problems with writing ☐ Difficulty with number skills ☐ Difficulty with reasoning and problem solving ☐ Memory problems ☐ Other – specify

Consumer Name:

Complete This Section For Adults (Age 18 and Over)

G7. What is the highest level of education you have completed?

- ☐ Less than High School
- ☐ Some High School
- ☐ GED
- ☐ Graduated Special Education
- ☐ High School Graduate
- ☐ Trade School
- ☐ Some College
- ☐ College Graduate
- ☐ Graduate Degree
- ☐ Unknown

Comments:

Complete This Section For Children (Age 17 and Under)

G8. What grade are you in? ☐ N/A

G9. Do you like school?

- ☐ Yes
- ☐ No
- ☐ N/A

If no, why not?

G10. *ASSESSOR:* Is the child following the school's attendance policy?

- ☐ Yes
- ☐ No
- ☐ N/A

If no, what are the circumstances?

G11. *ASSESSOR:* Does the child have a Special Education Plan?

- ☐ Yes (specify): ☐ IEP ☐ 504 Plan
- ☐ No
- ☐ N/A

G12. *ASSESSOR:* Is there an aide or mentor assigned to the child?

- ☐ Yes
- ☐ No
- ☐ N/A

G13. *ASSESSOR:* Is the child on target to graduate with his or her class?

- ☐ Yes
- ☐ No
- ☐ N/A

Case Management Comprehensive Assessment

Consumer Name:

Consumer Needs, Wants, and Desired Results Related to Education
What are your strengths and abilities related to education? *ASSESSOR*: List any other strengths and abilities not mentioned by the consumer or guardian: Do you have any other needs related to education that haven't been addressed above? *ASSESSOR*: List any other needs related to education not mentioned by the consumer or guardian. Do you have any wants related to education? What are your desired results related to education?

Case Management Comprehensive Assessment

Section H: Vocational

Complete this section for consumers age 14 or older.

H1. Do you work?

☐ Yes ☐ No ☐ N/A
Comments:

Questions for consumers who are currently working:

H2. What is your current work setting?

	Where Employed:
☐ Competitive employment: full-time	
☐ Competitive employment: part-time	
☐ Supported Employment	
☐ Enclave	
☐ Sheltered work	
If competitively employed, do you use natural supports in the work environment? ☐ Yes ☐ No	
Comments:	

H3. Are you happy in your current job?

☐ Yes ☐ No If no, what job would you like to do? Why does this job appeal to you?
Comments:

Questions for consumers who are not currently working:

H4. Are you able to work in the community?

☐ Yes ☐ No
Comments:

H5. Do you want to work in the community?

☐ Yes ☐ No If yes what job would you like to do? Why does this job appeal to you?
Comments:

Consumer Name:

Question for consumers who are working, or who are not working but are willing and able to work:

H6. Do you need help in any of the following areas?

	Yes	No
Looking for and obtaining a job	☐	☐
Job interviewing	☐	☐
Attending work as scheduled	☐	☐
Arriving to work on time and returning to work after lunch and breaks	☐	☐
Being appropriately dressed and groomed for work	☐	☐
Accepting work assignments and completing them according to instructions	☐	☐
Independently initiating work	☐	☐
Attending to work tasks without distraction	☐	☐
Following written directions	☐	☐
Performing a 1-step task	☐	☐
Performing a 2-3 step task	☐	☐
Communicating wants or needs	☐	☐
Timely informing employer when going to miss work	☐	☐
Accepting changes in schedule or routine	☐	☐
Getting along with co-workers	☐	☐
Other, including any barriers to obtaining employment:		
Comments:		

Consumer Needs, Wants, and Desired Results Related to Vocational Functioning

What are your strengths and abilities related to your vocational functioning?

ASSESSOR: List any other strengths and abilities not mentioned by the consumer or guardian:

Do you have any other needs related to your vocational functioning that haven't been addressed above?

ASSESSOR: List any other needs related to vocational functioning not mentioned by the consumer or guardian.

Do you have any wants related to your vocational functioning?

What are your desired results related to your vocational functioning?