ILLINOIS DEPARTMENT OF Healthcare and Family Services

☐ Initial
☐ Update
☐ Re-assessment

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

Address:	City:	State:	Zip Code:	County:

US Citizen: ☐ Yes ☐ No

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

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Insurance Coverage and Company: ☐ N/A

Household Size:

Household Income:

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

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

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

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

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

Parent, Guardian, or Significant Other Info.

First and Last Name: _____ Relationship to Client: ☐ Parent ☐ Guardian ☐ Significant Other Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____ County: _____

Emergency Contact Information

First and Last Name: _____ Relationship to Client: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Members of Family Constellation

Name	Age	Relation to Client	Living in Home
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

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

Client Initials:
DOB:

Unless otherwise stated, the following categories and action levels are used throughout to score individual CANS items:

0 = No evidence/no reason to believe item requires action. 2 = Need for Action. Some strategy is needed to address problem/need.

1 = Watchful waiting, monitoring or preventive action. 3 = Immediate/intensive action. Safety concern; priority for intervention.

Please note: Individual CANS items that are not applicable to the entire lifespan have specific age ranges for which the item must be completed indicated in front of the item name.

2. TRAUMA EXPOSURE

No = No evidence of any trauma of this type

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

POTENTIALLY TRAUMATIC/ADVERSE CHILDHOOD EXPERIENCES (ACEs)

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

Supporting Information: Provide additional information on the type of trauma experienced by the client (items rated YES) and the age of occurrence.

3. PRESENTING PROBLEM AND IMPACT ON FUNCTIONING

3a. Presenting Situation and Presenting Symptoms

BEHAVIORAL/EMOTIONAL NEEDS	n/a	0	1	2	3		n/a	0	1	2	3
Depression		☐	☐	☐	☐	3+: Impulsivity/Hyperactivity	☐	☐	☐	☐	☐
Anxiety		☐	☐	☐	☐	3+: Anger Control/Frustration Tolerance	☐	☐	☐	☐	☐
Eating Disturbance		☐	☐	☐	☐	6+: Substance Use [L – see p. 5]	☐	☐			
Adjustment to Trauma [A – see below]		☐	☐	☐	☐	6+: Psychosis (Thought Disorder)	☐	☐	☐	☐	☐
0-6: Regulatory	☐	☐	☐	☐	☐	6+: Conduct/Antisocial Behavior	☐	☐	☐	☐	☐
0-6: Failure to Thrive	☐	☐	☐	☐	☐	16+: Interpersonal Problems	☐	☐	☐	☐	☐
0-6: Atypical/Repetitive Behaviors [B – p. 3]	☐	☐				21+: Mania	☐	☐	☐	☐	☐
3-18: Oppositional (Non-compl. w/ auth.)	☐	☐	☐	☐	☐	21+: Somatization	☐	☐	☐	☐	☐

[A] TRAUMATIC STRESS SYMPTOMS MODULE (To complete when Behavioral/Emotional Needs, Adjustment to Trauma item is rated 1, 2 or 3)

Item	0	1	2	3	Item	0	1	2	3
Emotional and/or Physical Dysregulation	☐	☐	☐	☐	*Traumatic Grief & Separation*	☐	☐	☐	☐
Intrusions/Re-experiencing	☐	☐	☐	☐	*Numbing*	☐	☐	☐	☐
Hyperarousal	☐	☐	☐	☐	*Dissociation*	☐	☐	☐	☐
Attachment Difficulties	☐	☐	☐	☐	*Avoidance*	☐	☐	☐	☐

3b. Impact of Problems on Client's Functioning

LIFE FUNCTIONING	n/a	0	1	2	3		n/a	0	1	2	3
Family Functioning		☐	☐	☐	☐	0-6: Elimination	☐	☐	☐	☐	☐
Living Situation		☐	☐	☐	☐	0-21: School/Preschool/Daycare [C – see p. 3]	☐	☐			
Residential Stability		☐	☐	☐	☐	3+: Decision Making	☐	☐	☐	☐	☐
Social Functioning		☐	☐	☐	☐	6+: Legal [K – see p. 4]	☐	☐			
Recreation/Play		☐	☐	☐	☐	6+: Sexual Development	☐	☐	☐	☐	☐
Developmental/Intellectual [B – see p. 3]	☐	☐				16+: Job Functioning/Employment [D – see p. 3]	☐	☐			
Communication		☐	☐	☐	☐	16+: Parental/Caregiving Role [E – see p. 3]	☐	☐			
Medical/Physical		☐	☐	☐	☐	16+: Independent Living Skills [F – see p. 3]	☐	☐			
Medication Compliance		☐	☐	☐	☐	16+: Intimate Relationships	☐	☐	☐	☐	☐
Transportation		☐	☐	☐	☐	21+: Basic Activities of Daily Living	☐	☐	☐	☐	☐
1+: Sleep	☐	☐	☐	☐	☐	21+: Routines	☐	☐	☐	☐	☐
0-6: Motor	☐	☐	☐	☐	☐	21+: Functional Communication	☐	☐	☐	☐	☐
0-6: Sensory	☐	☐	☐	☐	☐	21+: Loneliness	☐	☐	☐	☐	☐

0-6: Persistence/Curiosity/Adaptability	☐ ☐ ☐ ☐ ☐

[B] DEVELOPMENTAL DISABILITIES MODULE (To complete when Life Functioning Domain, Developmental/Intellectual item or Emotional/Behavioral Needs Domain, Atypical/Repetitive Behaviors item is rated 1, 2 or 3)

Item	n/a	0	1	2	3	Item	n/a	0	1	2	3
Cognitive		☐	☐	☐	☐	*6+: Sensory*	☐	☐	☐	☐	☐
Developmental		☐	☐	☐	☐	*6+: Motor*	☐	☐	☐	☐	☐
Self-Care/Daily Living Skills		☐	☐	☐	☐	*6+: Regulatory*	☐	☐	☐	☐	☐
Autism Spectrum		☐	☐	☐	☐						

[C] SCHOOL/PRESCHOOL/DAYCARE MODULE (To complete when Life Functioning Domain, School/Preschool/Daycare item is rated 1, 2 or 3)

Item	n/a	0	1	2	3	Item	n/a	0	1	2	3
School/Preschool/Daycare Behavior		☐	☐	☐	☐	*Relationships with Teachers*		☐	☐	☐	☐
School/Preschool/Daycare Achievement		☐	☐	☐	☐	*Preschool/Daycare Quality*	☐	☐	☐	☐	☐
School/Preschool/Daycare Attendance		☐	☐	☐	☐						

School Needs: ☐ Educational Testing ☐ GED or Credit Recovery ☐ Student Study Team ☐ 504 Plan ☐ IEP ☐ Tutoring

[D] VOCATIONAL AND CAREER MODULE (To complete when Life Functioning Domain, Job Functioning/Employment item is rated 1, 2 or 3)

Item	0	1	2	3	Item	0	1	2	3
Career Aspirations	☐	☐	☐	☐	*Job Performance*	☐	☐	☐	☐
Job Time	☐	☐	☐	☐	*Job Relations*	☐	☐	☐	☐
Job Attendance	☐	☐	☐	☐	*Job Skills*	☐	☐	☐	☐

[E] PARENTING/CAREGIVING MODULE (To complete when Life Functioning Domain, Parental/Caregiving Role item is rated 1, 2 or 3)

Item	0	1	2	3	Item	0	1	2	3
Knowledge of Needs	☐	☐	☐	☐	*Organization*	☐	☐	☐	☐
Supervision	☐	☐	☐	☐	*Marital/Partner Violence In the Home*	☐	☐	☐	☐
Involvement with Care	☐	☐	☐	☐					

[F] INDEPENDENT ACTIVITIES OF DAILY LIVING MODULE (To complete when Life Functioning Domain, Independent Living Skills item is rated 1, 2 or 3)

Item	0	1	2	3	Item	0	1	2	3
Meal Preparation	☐	☐	☐	☐	*Money Management*	☐	☐	☐	☐
Shopping	☐	☐	☐	☐	*Communication Device Use*	☐	☐	☐	☐
Housework	☐	☐	☐	☐	*Housing Safety*	☐	☐	☐	☐

Supporting Information: Provide additional information regarding presenting situation and symptoms (Emotional/Behavioral items rated 2 and 3). Information on the impact of the presenting situation on the client's functioning (Life Functioning items rated 2 and 3) should also be included in the narrative. If Modules A-F are completed, please include items rated 2 and 3 in the narrative.

4. SAFETY

4a. Risk Behaviors

RISK BEHAVIORS	n/a	0	1	2	3		n/a	0	1	2	3
Victimization/Exploitation		☐	☐	☐	☐	6+: Delinquent/Criminal Behavior [K – see p. 4]	☐	☐	☐	☐	☐
0-6: Self-Harm	☐	☐	☐	☐	☐	6+: Non-Suicidal Self-Inj. Beh. (Self-Mutilation)	☐	☐	☐	☐	☐
3-6: Flight Risk	☐	☐	☐	☐	☐	6+: Other Self-Harm (Recklessness)	☐	☐	☐	☐	☐

Client Initials:
DOB:

3+: Suicide Risk	☐	☐	☐	☐	☐	6+: Danger to Others [I – see p. 4]	☐	☐	☐	☐	☐
3+: Intentional Misbehavior	☐	☐	☐	☐	☐	6+: Fire Setting [J – see p. 4]	☐	☐	☐	☐	☐
6-21: Runaway [G – see p. 4]	☐	☐	☐	☐	☐	21+: Grave Disability	☐	☐	☐	☐	☐
6+: Sexually Prob. Behavior [H – see p. 4]	☐	☐	☐	☐	☐	21+: Hoarding	☐	☐	☐	☐	☐
6+: Bullying Others	☐	☐	☐	☐	☐						

[G] RUNAWAY MODULE (To complete when Risk Behaviors Domain, Runaway item is rated 1, 2 or 3)

Item	0	1	2	3	Item	0	1	2	3
Frequency of Running	☐	☐	☐	☐	*Likelihood of Return on Own*	☐	☐	☐	☐
Consistency of Destination	☐	☐	☐	☐	*Involvement of Others*	☐	☐	☐	☐
Safety of Destination	☐	☐	☐	☐	*Realistic Expectations*	☐	☐	☐	☐
Involvement in Illegal Acts	☐	☐	☐	☐	*Planning*	☐	☐	☐	☐

[H] – SEXUALLY PROB. BEH. MODULE (To complete when Risk Behaviors Domain, Sexually Problematic Behavior item is rated 1, 2 or 3)

Item	0	1	2	3	Item	0	1	2	3
Hypersexuality	☐	☐	☐	☐	*Sexual Aggression [H1 – see below]*	☐	☐	☐	☐
High Risk Sexual Behavior	☐	☐	☐	☐	*Sexually Reactive Behavior*	☐	☐	☐	☐
Masturbation	☐	☐	☐	☐					

[H1] SEXUALLY AGGR. BEH. SUB-MODULE (To complete when Sexually Prob. Beh. Module, Sexual Aggression item is rated 1, 2 or 3)

Item	0	1	2	3	Item	0	1	2	3
Relationship	☐	☐	☐	☐	*Power Differential*	☐	☐	☐	☐
Physical Force/Threat	☐	☐	☐	☐	*Type of Sex Act*	☐	☐	☐	☐
Planning	☐	☐	☐	☐	*Response to Accusation*	☐	☐	☐	☐
Age Differential	☐	☐	☐	☐					

[I] DANGEROUSNESS MODULE (To complete when Risk Behaviors Domain, Danger to Others item is rated 1, 2 or 3)

Item	0	1	2	3	Item	0	1	2	3
Hostility	☐	☐	☐	☐	*Planning*	☐	☐	☐	☐
Paranoid Thinking	☐	☐	☐	☐	*Violence History*	☐	☐	☐	☐
Secondary Gains from Anger	☐	☐	☐	☐	*Aware of Violence Potential*	☐	☐	☐	☐
Violent Thinking	☐	☐	☐	☐	*Response to Consequences*	☐	☐	☐	☐
Intent	☐	☐	☐	☐	*Commitment to Self-Control*	☐	☐	☐	☐

[J] FIRE SETTING MODULE (To complete when Risk Behaviors Domain, Fire Setting item is rated 1, 2 or 3)

Item	0	1	2	3	Item	0	1	2	3
Seriousness	☐	☐	☐	☐	*Community Safety*	☐	☐	☐	☐
History	☐	☐	☐	☐	*Response to Accusation*	☐	☐	☐	☐
Planning	☐	☐	☐	☐	*Remorse*	☐	☐	☐	☐
Use of Accelerants	☐	☐	☐	☐	*Likelihood of Future Fire Setting*	☐	☐	☐	☐
Intention to Harm	☐	☐	☐	☐					

Supporting Information: Provide additional information regarding the client's risk behaviors, including aggressive/violent behavior/danger to others (items rated 2 and 3), and the level of impairment (e.g., school suspension, law enforcement involvement, crisis services, hospitalization).

[K] JUSTICE/CRIME MODULE (To complete when Life Functioning Domain, Legal item or Risk Behaviors Domain, Delinq./Criminal Beh. item is rated 1, 2 or 3)

Item	0	1	2	3	Item	0	1	2	3
Seriousness	☐	☐	☐	☐	*Community Safety*	☐	☐	☐	☐
History	☐	☐	☐	☐	*Legal Compliance*	☐	☐	☐	☐

Arrests	☐	☐	☐	☐	*Peer Influences*	☐	☐	☐	☐
Planning	☐	☐	☐	☐	*Environmental Influences*	☐	☐	☐	☐

Has the client ever been found by a criminal court to be: *(check all that apply)*

Unfit to Stand Trial (UST)? ☐ Yes ☐ No Date(s) of UST finding: _____

Not Guilty by Reason of Insanity (NGRI)? ☐ Yes ☐ No Date(s) of NGRI finding: _____

Supporting Information: Provide additional information regarding client's current and previous legal involvement, including any items rated 2 and 3 in the Justice/Crime Module. Include information on any findings of UST or NGRI, including whether the charges were for a misdemeanor or a felony.

4b. Factors in Current Environment

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

5. SUBSTANCE USE HISTORY

[L] SUBSTANCE USE MODULE (To complete when Behavioral/Emotional Needs, Substance Use item is rated 1, 2 or 3)

Item	0	1	2	3	Item	n/a	0	1	2	3
Severity of Use	☐	☐	☐	☐	*Peer Influences*		☐	☐	☐	☐
Duration of Use	☐	☐	☐	☐	*0-21: Parental Influences*	☐	☐	☐	☐	☐
Stage of Recovery	☐	☐	☐	☐	*21+: Recovery Support in Community*	☐	☐	☐	☐	☐
Environmental Influences	☐	☐	☐	☐						

Supporting Information: Provide additional information on client's substance/alcohol abuse (including Substance Use Module items rated 2 and 3, if completed). Specify onset, type – including tobacco and caffeine – frequency, amount and level of impairment (e.g., missing work/school, law enforcement/incarceration, family's level of concern and attempts to intervene).

Prior Substance Abuse Treatment: ☐ Yes ☐ No

When	Where	With Whom	Reason

6. PLACEMENT HISTORY

Describe previous and current out-of-home placements for the client including shelters, foster care, group home, nursing home, detention/incarceration, etc. ☐ Client has not had any out of home placements.

7. PSYCHIATRIC INFORMATION

7a. Psychiatric Problems

Describe significant psychiatric problems, treatments, and outcomes.

7b. General Mental Health History

Prior psychological assessment: ☐ Yes ☐ No Date: _____ IQ: _____ **Prior psychiatric evaluation**: ☐ Yes ☐ No Date: _____

Assessment Needs: ☐ Psychological Testing ☐ Psychiatric Evaluation **Prior Outpatient Mental Health Services:** ☐ Yes ☐ No

When	Where	With Whom	Reason

7c. Mental Status: Document clinical observations to support client's current mental status as noted below.

Appearance and Behavior:

Threatening:	☐ Yes	☐ No	Mood:	☐ WNL	☐ Depressed	☐ Manic	☐ Anxious	☐ Angry	
Suicidal:	☐ Yes	☐ No		☐ Expansive	☐ Labile				
Homicidal:	☐ Yes	☐ No	Affect:	☐ WNL	☐ Sad	☐ Angry	☐ Flat	☐ Constricted	
Impulse Control:	☐ Poor	☐ Good		☐ Inappropriate					
Hallucinatory:	☐ Yes	☐ No	Insight:	☐ Good	☐ Fair	☐ Poor			
Delusional:	☐ Yes	☐ No	Orientation:	☐ WNL	☐ Impaired				
Judgment:	☐ WNL	☐ Impaired	Cognition:	☐ WNL	☐ Loose Associations/Disorganized				
Memory:	☐ WNL	☐ Impaired	**Please note: WNL = Within Normal Limits**						

8. CLIENT STRENGTHS

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

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

Supporting Information: Provide additional information on client's strengths (items rated 0 and 1) – the aspects of the community and people in the client's network that provide support, and traits of the client that he/she has used to achieve his/her goals.

9. FAMILY INFORMATION

9a. Relevant Family History

Describe precipitating and other significant life events leading to current situation (e.g., divorce, immigration, level of acculturation/assimilation, losses, moves, financial difficulties, etc.). Please include: 1) family history of mental illness, 2) current court involvement (client and family).

9b. Cultural Considerations

CULTURAL FACTORS	0	1	2	3		0	1	2	3
Language	☐	☐	☐	☐	Cultural Stress	☐	☐	☐	☐
Traditions and Rituals	☐	☐	☐	☐					

Supporting Information: Provide additional information regarding the cultural factors (items rated 2 and 3) that may influence presenting problems (e.g., ethnicity, race, religion, spiritual practice, sexual orientation, transgender, socioeconomic status, living environment, etc.).

10. NEEDS/RESOURCE ASSESSMENT

☐ None. No additional needs/resources identified.

☐ Access to Food	☐ Educational Testing	☐ Mentoring	☐ Financial Assistance	☐ Immigration Assistance
☐ Clothing	☐ Employment	☐ Legal Assistance	☐ Physical Health	☐ Mental Health Service
☐ Shelter	☐ Other (specify): _____			

11. DIAGNOSIS

DSM-5 Diagnosis:		**ICD- 10 Diagnosis:**		**Preventive Diagnosis**
Diagnostic Code	DSM-5 Name	Diagnostic Code	ICD-10 Name	
_____	_____	_____	_____	☐
_____	_____	_____	_____	☐
_____	_____	_____	_____	☐
_____	_____	_____	_____	☐
_____	_____	_____	_____	☐

Client Initials:
DOB:

12. MENTAL HEALTH ASSESSMENT SUMMARY

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

13. ADDITIONAL CLIENT FUNCTIONING EVALUATIONS RECOMMENDED BY LPHA:

☐ No additional evaluations

14. SUMMARY OF PRIORITIZED CANS NEEDS AND STRENGTHS

14a. CANS Actionable Items to Consider for Treatment Planning

Background – Trauma Experiences

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

Background – Other Needs

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

Treatment Target Needs

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

Anticipated Outcome Needs

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

Centerpiece/Useful Strengths

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

Strengths to Build

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

Caregiver Resources

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

Caregiver Needs

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

15. INDIVIDUAL TREATMENT PLAN

15a. Client and Family Vision Statement For Treatment

15b. Client and Family Service Preferences.

Client Initials:	DOB:
Initial ☐ Update ☐ Reassessment ☐	

16. Treatment Goals and Objectives **Treatment Plan Date:**_____

All treatment goals and objectives should be stated in client/family language and should relate back to the CANS actionable items identified in box 14a. Goals are specific, observable outcomes related to functioning that result from targeting symptoms and behaviors. Objectives are the specific steps to reach the goal.

CANS Item(s): **CLIENT GOAL 1:**	**Goal Status:** ☐ Continue ☐ Discontinue ☐ Completed Date: _____
Clinical Objectives	
Objective 1a.	
Objective 1b.	
Objective 1c.	
CANS Item(s): **CLIENT GOAL 2:**	**Goal Status:** ☐ Continue ☐ Discontinue ☐ Completed Date: _____
Clinical Objectives	
Objective 2a.	
Objective 2b.	
Objective 2c.	
CANS Item(s): **CLIENT GOAL 3:**	**Goal Status:** ☐ Continue ☐ Discontinue ☐ Completed Date: _____
Clinical Objectives	
Objective 3a.	
Objective 3b.	
Objective 3c.	
CANS Item(s): **CLIENT GOAL 4:**	**Goal Status:** ☐ Continue ☐ Discontinue ☐ Completed Date: _____
Clinical Objectives	
Objective 4a.	
Objective 4b.	
Objective 4c.	
CANS Item(s): **CLIENT GOAL 5:**	**Goal Status:** ☐ Continue ☐ Discontinue ☐ Completed Date: _____
Clinical Objectives	
Objective 5a.	
Objective 5b.	

Objective 5c.	

Client Initials:	DOB:
Initial ☐ Update ☐ Reassessment ☐	

Use the service key and mode key below to complete the service section of the treatment plan. For services not listed, please indicate "Other" in the Service Type line and specify the services/interventions to be pursued.

SERVICE TYPE	KEY	SERVICE TYPE	KEY	SERVICE TYPE	KEY	SERVICE TYPE	KEY
Therapy/Counseling	TC	Assertive Comm. Treatment	ACT	Case Mgmt -Transition Linkage, Aftercare	TLA	Psych Med Administration	PMA
Community Support	CS	Case Mgmt -Mental Health	MH	Mental Health Intensive Outpatient	IO	Psych Med Monitoring	PMM
Community Support Team	CST	Case Mgmt -Client Centered Consultation	CCC	Psychosocial Rehabilitation	PSR	Psych Med Training	PMT

SERVICE MODE KEY	PLACE OF SERVICE KEY
Individual= I Group= G Family= F Residential= R	On-Site= ON Off-Site= OFF

17. Services/Interventions

Objective(s)	Service Type	Mode	Place of Service	Amount	Frequency	Duration	Agency and Staff Responsible

IM+CANS SIGNATURES

By signing this you agree that you have participated in the mental health assessment and treatment planning process and have been given a copy of the completed IM+CANS. You agree that you have had a chance to review the IM+CANS in full, and that the contents have been explained to you in a language that you understand. You understand the risks and benefits of the services outlined in the treatment plan and consent to the services as outlined in this plan. **Please document if a youth 12 years of age or older refuses to sign.**

CLIENT SIGNATURE (required for all clients 12 years of age or older)			PARENT/LEGAL GUARDIAN SIGNATURE		
Client (print name)	Signature	Date (mm/dd/yyyy)	Parent/Legal Guardian (print name)	Signature	Date (mm/dd/yyyy)

STAFF RESPONSIBLE FOR IM+CANS DEVELOPMENT, REVIEW, AND MODIFICATION SIGNATURE

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