This is a sample form developed by the "CCS Statewide QA/QI Work Group", and is available to CCS sites as a sample for consideration of use, modification, and customization. There is no implicit or explicit guarantee that this document meets the requirements for CCS as outlined in DHS 36, Medicaid, or other applicable laws, rules, or regulations. Individual counties and tribes are responsible for developing their own forms and ensuring adherence to all applicable laws, rules, and regulations. The hope is that this working draft is modified based on the experiences and expertise of state, county, and tribal partners, and as new information becomes available.

Comprehensive Community Services (CCS) Comprehensive Assessment

Consumer's Name: Consumer's Name

Date of Birth: Date of Birth **Service Facilitator:** Service Facilitator

Instructions: The comprehensive assessment and recovery plan should be completed within 30 days of receipt of the consumer's application for CCS (unless an abbreviated process is necessary), and should incorporate, to the greatest extent possible, the *consumer's unique perspective and own words about how he or she views his or her recovery, experience, challenges, strengths, resources, and needs* in each of the domains.

The consumer's completed **Functional Eligibility Screen** should serve as a supplemental tool to this document.

Each domain includes an "overview" section with items that can be identified as either a strength, need, or not a need – one of these options should always be checked. Please also always complete the "Consumer Priority Yes / No" column.

Basic Needs

1. **Basic needs include things like food, shelter, clothing, and safety. Do you feel your basic needs are met?** Consumer's Comments
2. **Are there other things you consider your "basic needs?** Consumer's Comments
3. **What basic needs are not being met?** Consumer's Comments

Basic Needs Overview – Access to Food, Access to Shelter, Clothing, and Safety	Strength	Need	Not a Need	Consumer Priority? YES	NO
Foodshare					
Local pantries					
Transportation (related to food access)					
Has a safe place to sleep at night					
Working utilities					
Conditions are safe					
Has weather-appropriate clothing					
Adequate supervision (minor)					
Other: Consumer's Comments					

Additional consumer comments, notes, or collateral information:

Applicable age or developmental factors:

Consumer identified goal(s): How will you know when things are better? What will it look like when your goals in this area are met?

Possible options for treatment, Psychosocial Rehabilitative Services, and self-help programs to address the consumer's priorities or goals: Options discussed

Updates related to progress or needs, include dates of each update: Updates – include date for each update

Social Network and Family Involvement

1. **Who do you currently have for support in your life?** Consumer's Comments

2. **How do you feel supported by these people or how would you like to feel more supported?** Consumer's Comments

3. **Where do you feel you most need additional support in your life at this time?** Consumer's Comments

Social Network & Family Involvement Overview – Natural Supports, Other Supports and Social Outlets	Strength	Need	Not a Need	Consumer Priority? YES	NO
Supported by nuclear family					
Supported by extended family					
Supported by friends/social resources					
Has the support of psychotherapist, case manager, skill provider					
Has the support of teacher, coach, pastor, community member					
Has access to peer support					
Has identified hobbies or interests					
Has a positive social activity/involved in community/volunteers					
Other: Consumer's Comments					

Additional consumer comments, notes, or collateral information:

Applicable age or developmental factors:

Consumer identified goal(s): How will you know when things are better? What will it look like when your goals in this area are met?

Possible options for treatment, Psychosocial Rehabilitative Services, and self-help programs to address the consumer's priorities or goals: Options discussed

Updates related to progress or needs, include dates of each update: Updates – include date for each update

Community Living Skills

Please refer to the following sections of the consumer's Functional Eligibility Screen: ***Community Living Skills Inventory*** *for an adult consumer, or* ***Activities of Daily Living Skills*** *and* ***Instrumental Activities of Daily Living*** *sections for a youth consumer. Use the information as a base for discussion and consider the following questions:*

Community Living Skills Overview	Strength	Need	Not a Need	Consumer Priority? YES	NO
Age-appropriate hygiene					
Laundry					
Maintain clean living environment					
Driver's license/transportation: source					
Navigating public transportation					
Medical transportation					
Meal Preparation					
Grocery and personal needs Shopping					
Time management/ability to track and attend appointments					
Home Safety skills (e.g. monitoring stove top, locking doors)					
Community Safety skills (e.g. "stranger danger", accessing 911)					

Sample

Use of cell phone/access to landline/communication skills					
Can identify needs and seek appropriate assistance					
Other: Consumer's Comments					

Additional consumer comments, notes, or collateral information:

Applicable age or developmental factors:

Consumer identified goal(s): How will you know when things are better? What will it look like when your goals in this area are met?

Possible options for treatment, Psychosocial Rehabilitative Services, and self-help programs to address the consumer's priorities or goals: Options discussed

Updates related to progress or needs, include dates of each update: Updates – include date for each update

Employment

*Please refer to the **Vocational Information** and **Demographics: Medical Insurance** (for adult consumer), or **School and Work** (for youth consumer) section of the consumer's Functional Eligibility Screen. Use the information as a base for discussion and consider the following questions:*

1. **Are you currently employed?** Consumer's Comments **If so, where, and how many hours per week? If not, are you interested in employment?** Consumer's Comments
2. **Impact of work on mental or physical Health:** Consumer's Comments
3. **List previous employers and length of time on the job**: Consumer's Comments
4. **List any current employment related services (e.g. sheltered workshops, supported employment, or DVR):** Consumer's Comments
5. **Please describe your dream job:** Consumer's Comments

Employment Overview	**Strength**	**Need**	**Not a Need**	**Consumer Priority? YES**	**NO**
Would like a better/different job					
Have access to transportation to/from work					
Experience symptoms that impact work					
Feel some sense of job satisfaction					
Have work appropriate clothing					
Have work appropriate hygiene skills					
Currently seeking or interested in work					
Interest in developing employment related skills					
Current volunteer hours per week:					
Interest in developing employment-related skills					
Interviewing skills					
Resume or application skills					
Other: Consumer's Comments					

Additional consumer comments, notes, or collateral information:

Applicable age or developmental factors:

Sample

Consumer identified goal(s): How will you know when things are better? What will it look like when your goals in this area are met?

Possible options for treatment, Psychosocial Rehabilitative Services, and self-help programs to address the consumer's priorities or goals: Options discussed

Updates related to progress or needs, include dates of each update: Updates – include date for each update

Housing Issues

*Please refer to the **Living Situation** section of the consumer's Functional Eligibility Screen. Use the information as a base for discussion and consider the following questions:*

1. **Describe your current living situation (own home, supported environment, lives alone or with others).** Consumer's Comments
2. **What do you like about your current living situation?** Consumer's Comments
3. **What would you change if you could?** Consumer's Comments

Housing Issues Overview	Strength	Need	Not a Need	Consumer Priority? YES	NO
Lives in preferred residence					
Current residence allows for desired level of independence/support					
Adequate space					
Accessibility of neighborhood					
Present housing stability					
History of housing stability					
Access to safe housing options					
Functional residence (heat, electricity, appliances, structure)					
Other barriers to housing					
Housing assistance (Subsidized, Rental Assistance)					
Other: Consumer's Comments					

Additional consumer comments, notes, or collateral information:

Applicable age or developmental factors:

Consumer identified goal(s): How will you know when things are better? What will it look like when your goals in this area are met?

Possible options for treatment, Psychosocial Rehabilitative Services, and self-help programs to address the consumer's priorities or goals: Options discussed

Updates related to progress or needs, include dates of each update: Updates – include date for each update

Finances and Benefits

1. **How are you/your family financially supported?** Consumer's Comments
2. **Have there been any times in the last six months your finances were insufficient to meet you (your family's) needs? Describe.** Consumer's Comments

Finances/Benefits Overview – Connected to Eligible Benefits	Strength	Need	Not a Need	Consumer Priority?

Sample

				YES	NO
SSI/SSDI					
Medicaid/Medicare/Private Insurance					
Unemployment					
Foodshare and/or WIC					
Housing Assistance					
Energy Assistance					
Current finances/benefits cover necessities					
Bills are consistently paid					
Follows a developed budget					
Informal or formal support (payee or guardian of estate) with budget					
Has a savings/checking account					
Debt management/credit counseling					
Able to identify scams and risks					
Financial Conservatorship/Durable Power of Attorney for Finances					
Other:					

Additional consumer comments, notes, or collateral information:

Applicable age or developmental factors:

Consumer identified goal(s): How will you know when things are better? What will it look like when your goals in this area are met?

Possible options for treatment, Psychosocial Rehabilitative Services, and self-help programs to address the consumer's priorities or goals: Options discussed

Updates related to progress or needs, include dates of each update: Updates – include date for each update

Education

*If the consumer is a **youth**, please refer to the **School and Work** section of their Functional Eligibility Screen. Use the information as a base for discussion. If the consumer is an **adult**, please refer to the **Vocational Information** section of their Functional Eligibility Screen.*

1. **What is your current level of education?** Consumer's Comments
2. **Any desire to further your education?** Consumer's Comments
3. **What educational needs are not being met?** Consumer's Comments

Education Overview	Strength	Need	Not a Need	Consumer Priority? YES	NO
School attendance					
Grades					
Disciplinary issues					
Extracurricular activities					
Expulsions/suspensions					
Positive relationships/friends					
Has an IEP in place					
Understands the IEP					
Desires furthering education					
Knows who to contact regarding questions					

Sample

Able to fill out paperwork					
Other: Consumer's Comments					

Additional consumer comments, notes, or collateral information:

Applicable age or developmental factors:

Consumer identified goal(s): How will you know when things are better? What will it look like when your goals in this area are met?

Possible options for treatment, Psychosocial Rehabilitative Services, and self-help programs to address the consumer's priorities or goals: Options discussed

Updates related to progress or needs, include dates of each update: Updates – include date for each update

Mental Health / Behavioral Health

*Please refer to the **Mental Health and AODA Diagnoses** section (for adult consumer), or **Behaviors, Mental Health, and Diagnoses** sections (for youth consumer) of the consumer's Functional Eligibility Screen. Use the information as a base for discussion and consider the following questions:*

Current Providers		Frequency of contact
Psychiatrist:		
Counselor/Therapist:		
Other:		

Diagnoses: Click here to enter text.

1. **Please describe past inpatient treatment – where it occurred, for how long, and who the provider was**: Consumer's Comments
2. **Please describe past outpatient treatment – where it occurred, for how long, and who the provider was**: Consumer's Comments
3. **What aspects of past treatment do you feel were affective or ineffective?** Consumer's Comments
4. **Please list all past testing including but not limited to: IQ, neuropsychological, competency evaluations, physiological, functional, cognitive, developmental, and behavioral.** Consumer's Comments

Mental Health / Behavioral Health Overview	Strength	Need	Not a Need	Consumer Priority? YES	NO
Understand current diagnosis					
Agrees with current diagnosis					
Utilizes coping skills					
Understands basics of sleep hygiene					
Has a developed routine					
Satisfied with providers					
Family has awareness/understanding of mental health condition					
Other: Consumer's Comments					

Symptom	Behavioral Response or Coping Mechanism	Strength	Need	Not a Need	Consumer Priority? YES	NO

Sample

Mental Status Exam

Conscious/Orientation: ☐Alert ☐Fully Oriented ☐Disoriented ☐ Clarify: Click here to enter text.

Attitude: Attitude: ☐Friendly ☐Cooperative ☐Ingratiating ☐Playful ☐Attentive ☐Indifferent ☐Evasive ☐Hostile ☐Guarded

Appearance: ☐Appropriate hygiene ☐Body odor ☐Disheveled ☐Inappropriate for weather ☐Colorful ☐Obese ☐Emaciated ☐Scars/tattoos/piercings ☐Other: Click here to enter text.

Motor Activity: ☐Normal ☐Agitated ☐Posturing ☐Psychomotor retardation ☐Slowed ☐Gesturing ☐Other: Click here to enter text.

Speech: ☐Normal ☐Slurred ☐Mumbled ☐Accent ☐Slowed☐Pressured ☐Mute ☐Rapid ☐Loud ☐Talkative ☐Unspontaneous ☐Hesitant ☐Echolalia ☐Other: Click here to enter text.

Affect: ☐Appropriate ☐Labile ☐Restricted ☐Blunted ☐Incongruent ☐Irritable ☐Hostile ☐Fearful ☐Tense ☐Expansive ☐Other: Click here to enter text.

Mood:☐Euthymic ☐Dysphoric ☐Elevated ☐Depressed ☐Dysthymic

Memory: ☐Normal ☐Immediate Impaired ☐Recent Impaired☐Remoted Impaired ☐Confabulation

Orientation: ☐X3 ☐Time disorientation ☐Place disorientation ☐Person Disorientation

Judgement/Insight: ☐Intact ☐Impaired Insight ☐Denial ☐External Locus ☐Other: Click here to enter text.

Attention/Concentration: ☐Good Inattentive ☐Confused ☐Vigilant ☐Selective ☐Other: Click here to enter text.

Sensorium and Cognition: ☐Normal ☐Disoriented ☐Cognitive Clouding ☐Delirium ☐Somnolence

Thought Form: ☐Linear/Goal Directed ☐Circumstantial ☐Tangential Neologism ☐Thought Blocking ☐Perseveration ☐Word Salad ☐Flight of Ideas ☐Derailment ☐Loose Association ☐Other: Click here to enter text.

Thought Content: ☐No abnormalities ☐Poverty of Thought ☐Delusions: ☐Bizarre ☐Mood- congruent ☐incongruent ☐Somatic ☐Paranoid ☐Persecutory ☐Grandiose ☐Referential ☐Thought Insertion ☐Thought Broadcasting ☐Preoccupations: Click here to enter text. ☐Obsessions: Click here to enter text. ☐Compulsions: Click here to enter text.

Perceptions: ☐ No abnormalities ☐Anosognosia ☐Disassociation ☐Derealization ☐Depersonalization ☐Hallucinations ☐Visual ☐Auditory ☐Olfactory ☐Tactile ☐Somatic: Describe: Click here to enter text.

Narrative (Include Consumer/parent/guardian description of illness onset, course of treatment, and response to treatment. Include any relevant facts about mental health not captured above, along with cultural and environmental factors that influence the consumer's mental health). Click here to enter text.

Additional consumer comments, notes, or collateral information:

Applicable age or developmental factors:

Consumer identified goal(s): How will you know when things are better? What will it look like when your goals in this area are met?

Sample

Possible options for treatment, Psychosocial Rehabilitative Services, and self-help programs to address the consumer's priorities or goals: Options discussed

Updates related to progress or needs, include dates of each update: Updates – include date for each update

Physical Health / Medical

*Please refer to the **Other Diagnoses** section (for adult consumer), or **Diagnoses, Health Related Services, and Primary Care Physician Information** sections (for youth consumer) of the consumer's Functional Eligibility Screen. Use the information as a base for discussion and consider the following questions:*

1. **Do you feel your (and your family's) health/medical needs are met?** Consumer's Comments
2. **What health/medical needs are not being met?** Consumer's Comments
3. **Who is your current Primary Care provider?** Consumer's Comments
4. **Current Medical diagnoses:** Consumer's Comments
5. **Do you have any allergies?** Consumer's Comments

Physical Health / Medical Overview – Health, Dental, and Vision Care, and Medications	**Strength**	**Need**	**Not a Need**	**Consumer Priority? YES**	**NO**
Knows how to access medical care					
Has Doctor that is seen regularly					
Preventative care needs met					
Knows how to access dental care					
Has a Dentist that is seen regularly					
Preventative care needs met					
Knows how to access vision care					
Has Eye Doctor that is seen as needed					
Knowledge of insurance coverage benefits					
Communicates effectively with providers					
Understands diagnoses					
Understands treatment					
Medical advocacy					
Power of Attorney for Health Care					
Other: Consumer's Comments					

Additional consumer comments, notes, or collateral information:

Applicable age or developmental factors:

Consumer identified goal(s): How will you know when things are better? What will it look like when your goals in this area are met?

Possible options for treatment, Psychosocial Rehabilitative Services, and self-help programs to address the consumer's priorities or goals: Options discussed

Updates related to progress or needs, include dates of each update: Updates – include date for each update

Sample

Medications

Please refer to the ***Taking Medications,*** *and* ***Monitoring Medication Effects*** *portions of the* ***Community Living Skill Inventory*** *section (for adult consumer) of the consumer's Functional Eligibility Screen. Use the information as a base for discussion and consider the following questions:*

Current Prescribed Medications

1. Name/Dose/Frequency/Route Prescribing Physician

   Purpose: Purpose

   Notes: Consumer's perspective on effectiveness, side effects, any issues, etc.

2. Name/Dose/Frequency/Route Prescribing Physician

   Purpose: Purpose

   Notes: Consumer's perspective on effectiveness, side effects, any issues, etc.

3. Name/Dose/Frequency/Route Prescribing Physician

   Purpose: Purpose

   Notes: Consumer's perspective on effectiveness, side effects, any issues, etc.

4. Name/Dose/Frequency/Route Prescribing Physician

   Purpose: Purpose

   Notes: Consumer's perspective on effectiveness, side effects, any issues, etc.

If there are additional prescribed medications, please attach the information.

Current Over the Counter Medications

1. Name/Dose/Frequency/Route Purpose, effectiveness, side effects, how long taken, any issues, etc.
2. Name/Dose/Frequency/Route Purpose, effectiveness, side effects, how long taken, any issues, etc.
3. Name/Dose/Frequency/Route Purpose, effectiveness, side effects, how long taken, any issues, etc.
4. Name/Dose/Frequency/Route Purpose, effectiveness, side effects, how long taken, any issues, etc.

If there are additional over the counter medications, please attach the information.

1. **Are there medications you took in the past to address mental health symptoms you found effective? How did this impact you?** Consumer's Comments

2. **Are there medications you took in the past you found ineffective? How did this impact you?** Consumer's Comments

3. **Have you had any allergic reactions to any medications? If yes, what medications and what was the reaction?** Consumer's Comments

Medications Overview	Strength	Need	Not a Need	Consumer Priority?
Takes medications as prescribed				
Knows names, dosages, frequency of prescribed medications				
Set up of medications (bottles, blister packs, med minder)				
Safely administers				
Remembers to take at prescribed times				
Assistance with medication administration				
Able to describe symptoms/symptom improvement to providers				
Able to identify side effects to providers				
Navigates changes with pharmacy				

Sample

Other: Consumer's Comments				

Additional consumer comments, notes, or collateral information:

Applicable age or developmental factors:

Consumer identified goal(s): How will you know when things are better? What will it look like when your goals in this area are met?

Possible options for treatment, Psychosocial Rehabilitative Services, and self-help programs to address the consumer's priorities or goals: Options discussed

Updates related to progress or needs, include dates of each update: Updates – include date for each update

Substance Use

Note: Substance use diagnoses shall be established by a substance abuse professional. An assessment of the consumer's substance use, strengths and treatment needs also shall be conducted by a substance abuse professional. DHS 36.16(2)(c)

*Please refer the **Mental Health and AODA Diagnosis** and **Risk Factors** sections (for adult consumer), or **High-Risk Behaviors** section (for youth consumer) of the consumer's Functional Eligibility Screen. Use the information as a base for discussion and consider the following questions:*

In the past 12 months,

1. **Have you used substances other than those required for medical reasons?** Consumer's Comments
2. **Do you abuse more than one substance at a time?** Consumer's Comments
3. **Are you always able to stop using substances when you want to?** Consumer's Comments
4. **Have you had "blackouts" or "flashbacks" as a result of your substance use?** Consumer's Comments
5. **Do you ever feel bad or guilty about your substance use?** Consumer's Comments
6. **Does your spouse (or family members) ever complain about your involvement with substances?** Consumer's Comments
7. **Have you neglected your family because of your use of substances?** Consumer's Comments
8. **Have you engaged in illegal activities in order to obtain substances?** Consumer's Comments
9. **Have you ever experienced withdrawal symptoms (felt sick) when you stopped using substances**? Consumer's Comments
10. **Have you had any medical problems as a result of your drug use (memory loss, injury, etc.)?** Consumer's Comments

Substances Used	Times in Past Week	Times in Past Month	Times in Past Year
Alcohol			
Marijuana			
Ecstasy/MDMA			
Cocaine			
Methamphetamine			
Heroin			
Crack			
Synthetics (Spice, K2, Bath Salts, etc.)			
Prescription Opiates (Oxycodone, Vicodin, Morphine, Codeine, etc.)			

Sample

Prescription Amphetamines (Adderall, Ritalin, Vyvanse, etc.)			
Prescription Benzodiazepines (Xanax, Valium, Ativan, etc.)			
Other: Consumer's Comments			

Substance Use Overview – Services and Supports	**Strength**	**Need**	**Not a Need**	**Consumer Priority? YES**	**NO**
Aware of A.A./N.A./Support Groups					
Aware of Treatment Services					
Able to access services					
Parents/Spouse currently have substance use issues					
Has sober support					
Family is supportive					
Other: Consumer's Comments					

Additional consumer comments, notes, or collateral information:

Applicable age or developmental factors:

Consumer identified goal(s): How will you know when things are better? What will it look like when your goals in this area are met?

Possible options for treatment, Psychosocial Rehabilitative Services, and self-help programs to address the consumer's priorities or goals: Options discussed

Updates related to progress or needs, include dates of each update: Updates – include date for each update

Content adapted from the DAST

Sample

Trauma and Significant Life Stressors

*Please refer to the **Mental Health and AODA Diagnoses** section (for adult consumer), or **Behaviors, Mental Health, and Diagnoses** sections (for youth consumer) of the consumer's Functional Eligibility Screen. Use the information as a base for discussion and consider the following questions:*

1. **What causes you to feel stressed? When you are stressed, who or what calms you?** Consumer's Comments

2. **Are there events in your life you would consider traumatic? How did these events affect you?** Consumer's Comments

3. **Have you experienced any of the following at any time in your life?**

   a) **Witnessed someone seriously injured or killed due to an unnatural event such as a shooting or auto accident?** ☐ Yes ☐ No ☐ Not Sure Consumer's Comments

   b) **Experienced a natural disaster, severe accident, or threat to your life?** ☐ Yes ☐ No ☐ Not Sure Consumer's Comments

   c) **Had a child/loved one experience a serious medical, mental health, or developmental setback?** ☐ Yes ☐ No ☐ Not Sure Consumer's Comments

   d) **Witnessed a physical or sexual assault against a family member or significant person?** ☐ Yes ☐ No ☐ Not Sure Consumer's Comments

   e) **Been forced to have sexual contact, to touch someone sexually, or be touched sexually when you did not want them to?** ☐ Yes ☐ No ☐ Not Sure Consumer's Comments

   f) **Has anyone slapped, pushed, grabbed, shoved, choked, kicked, bit, or punched you?** ☐ Yes ☐ No ☐ Not Sure Consumer's Comments

g) **Been threatened with, or actually used a knife, gun, or other weapon to scare or harm you?** ☐ Yes ☐ No ☐ Not Sure Consumer's Comments

h) **Been afraid that a specific person (known to you well or not) would harm you physically?** ☐ Yes ☐ No ☐ Not Sure Consumer's Comments

i) **Are there other events in your life that have been traumatic for you?** ☐ Yes ☐ No ☐ Not Sure Consumer's Comments

If the answer to any part of this question is "Yes" or "Not Sure", please continue with question 4, otherwise mark question 4 as N/A.

4. **Have you experienced any of the following: flashbacks, nightmares, significant anxiety, or intrusive thoughts related to your traumatic experience(s)?** ☐ Yes ☐ No Consumer's Comments

Content adapted from the Wisconsin CANS

Trauma and Significant Life Stressors Overview	Strength	Need	Not a Need	Consumer Priority? YES	NO
Has at least one adult who believes the consumer					
Able to verbalize aspects of traumatic experience					
Identifies coping skills to manage trauma related thoughts/emotions					
Attributes responsibility appropriately (does not engage in self-blame)					
Engages in safe interpersonal relationships					
Other: Consumer's Comments					

Additional consumer comments, notes, or collateral information:

Applicable age or developmental factors:

Consumer identified goal(s): How will you know when things are better? What will it look like when your goals in this area are met?

Possible options for treatment, Psychosocial Rehabilitative Services, and self-help programs to address the consumer's priorities or goals: Options discussed

Updates related to progress or needs, include dates of each update: Updates – include date for each update

Supplemental Tools may include: ACES, The PTSD Checklist for DSM-5, The Child PTSD Symptom Scale (CPSS)

Sample

Crisis Prevention and Management

*Please refer to the **Crisis and Situational Factors** and **Risk Factors** sections (for adult consumer), or **Behaviors** section (for youth consumer) of the consumer's Functional Eligibility Screen. Use the information as a base for discussion and consider the following questions:*

1. **What are some of your triggers that have or could potentially result in crisis situations?** Consumer's Comments

2. **What helps you to calm you down/what coping skills do you use?** Consumer's Comments

3. **Who are the support people you can turn to in times of crisis?** Consumer's Comments

4. **Who should be contacted for you if there is an emergency?** Consumer's Comments

Overview of Crisis Prevention and Management	Strength	Need	Not a Need	Consumer Priority? YES	NO

Knows how to access the crisis line if needed					
Has an active crisis plan on file with the county					
Has the support of family, friends, social resources					
Has a safe place to go in times of need					
Is able to identify their triggers and utilizes coping skills to manage them.					
Takes medication as prescribes					
Meets with their psychotherapist consistently					
Is currently self-harming or has in the last 6 months					
Has attempted suicide in the last 6 months					
Is engaging in high risk behaviors (running away, drug use, criminal charges)					
Other: Consumer's Comments					

Additional consumer comments, notes, or collateral information:

Applicable age or developmental factors:

Consumer identified goal(s): How will you know when things are better? What will it look like when your goals in this area are met?

Possible options for treatment, Psychosocial Rehabilitative Services, and self-help programs to address the consumer's priorities or goals: Options discussed

Updates related to progress or needs, include dates of each update: Updates – include date for each update

Legal Status

*Please refer to the **Legal Concerns** section (for youth consumer) of the consumer's Functional Eligibility Screen. Use the information as a base for discussion and consider the following questions:*

1. **Do you currently have any legal and/or pending charges? If so, what for?** Consumer's Comments

2. **Other information we should know related to your legal status?** Consumer's Comments

3. **Are there any legal custody arrangements to be aware of for minor children?**

Overview of Legal Status	Strength	Need	Not a Need	Consumer Priority? YES	NO
Has no current or pending legal problems					
Is compliant with legal requirements					
Has a positive environment- not being influenced by risky behavior					
Family and friends do not engage in illegal activity					

	YES	NO		Contact
Is there a CHIPS				
Is there JIPS				
Is there a guardianship				
Do you have a POA				
Probation and Parole				
Chapter 51				
Settlement				
Commitment				

Sample

Medication order				
Treatment court				
Other: Consumer's Comments				

Additional consumer comments, notes, or collateral information:

Applicable age or developmental factors:

Consumer identified goal(s): How will you know when things are better? What will it look like when your goals in this area are met?

Possible options for treatment, Psychosocial Rehabilitative Services, and self-help programs to address the consumer's priorities or goals: Options discussed

Updates related to progress or needs, include dates of each update: Updates – include date for each update

Cultural and Spiritual

1. **Describe ethnic or national traditions or holidays you observe. How do you participate in these traditions?** Consumer's Comments
2. **Do you have spiritual beliefs that provide comfort?** Consumer's Comments
3. **Are you involved with a religious community?** Consumer's Comments
4. **Are there any barriers to participating in cultural or spiritual traditions or activities you are interested in?** Consumer's Comments
5. **Does language interfere with participation in any activities?** Consumer's Comments
6. **Are there times you experience discrimination or discomfort based on your race, religion, gender, or sexual orientation?** Consumer's Comments

Overview of Cultural and Spiritual	Strength	Need	Not a Need	Consumer Priority? YES	NO
Knowledge of desired cultural supports					
Knowledge of desired religious supports					
Access to desired cultural supports					
Access to desired religious supports					
Other: Consumer's Comments					

Additional consumer comments, notes, or collateral information:

Applicable age or developmental factors:

Consumer identified goal(s): How will you know when things are better? What will it look like when your goals in this area are met?

Possible options for treatment, Psychosocial Rehabilitative Services, and self-help programs to address the consumer's priorities or goals: Options discussed

Updates related to progress or needs, include dates of each update: Updates – include date for each update

Life Satisfaction

Sample

1. **When was the last time you had a good day? What made it a good day?** Consumer's Comments
2. **What happens in a typical day for you?** Consumer's Comments
3. **What do you do for fun?** Consumer's Comments
4. **What aspects of your life do you like?** Consumer's Comments
5. **What would you change if you could?** Consumer's Comments

Overview of Life Satisfaction	Strength	Need	Not a Need	Consumer Priority? YES	NO
Belief in recovery (Hope*)					
Identifies choices in recovery (Person-driven*)					
Identifies multiple pathways, such as counseling, medications; cultural, family, or peer support (Pathways*)					
Identifies positive and meaningful sense of identity (Respect*)					
Identifies community acceptance (Respect*)					
Participates in meaningful/enjoyable activities					
Other: Consumer's Comments					

Additional consumer comments, notes, or collateral information:

Applicable age or developmental factors:

Consumer identified goal(s): How will you know when things are better? What will it look like when your goals in this area are met?

Possible options for treatment, Psychosocial Rehabilitative Services, and self-help programs to address the consumer's priorities or goals: Options discussed

Updates related to progress or needs, include dates of each update: Updates – include date for each update

** Adapted from the 10 principles of Recovery, SAHMSA*

Additional Needs and Strengths

1. **Are there additional areas of strength such as hobbies, talents, hopes, and dreams that you would like to share?** Consumer's Comments
2. **Are there any additional areas of need or barriers that you would like to discuss?** Consumer's Comments
3. **Additional consumer comments, notes, or collateral information:** Additional comments or notes, including possible options for treatment, Psychosocial Rehabilitative Services, and self-help programs to address the consumer's priorities or goals. Address any applicable age or developmental factors.
4. **Additional consumer goal(s):** How will you know when things are better? What will it look like when your goals in this area are met?

Signature

Service Facilitator (printed)	Signature	Date

Sample