HFS
Illinois Department of Healthcare and Family Services

☐ Initial
☐ Update
☐ Re-assessment

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

1. GENERAL INFORMATION

Customer First and Last Name:	Chosen/Preferred Name:	Pronouns:	Date First Contact:	Referral Source:

RIN:	Date of Birth:	Sex at Birth:	Gender Identity:	Phone Number:	Primary Language:

Address:	City:	State:	Zip Code:	County:

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

Ethnicity: ☐ Hispanic or Latinx ☐ Unknown ☐ Non-Hispanic or Latinx

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

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

Insurance Coverage:	Household Size:	Household Income:

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

Living Arrangement:
☐ Private residence ☐ Homeless/shelter ☐ Jail/correctional facility
☐ Foster home ☐ State op. facility (MH/DD) ☐ Other: _____
☐ Supportive/assisted living ☐ Residential/institution

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

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

2. ESTABLISHED SUPPORTS

Does the customer have one or more caregivers? ☐ Yes (please complete the Caregiver Addendum) ☐ No

Caregiver or Significant Other Info.
First and Last Name: _____ Relationship to Customer: ☐ Parent ☐ Legal guardian ☐ Other caregiver ☐ 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

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

Iroquois Mental Health Center

Would you like your primary doctor to be contacted about your mental health care? ☐ YES ☐ NO

Please check your current symptoms:

☐ Y ☐ N	Depressed Mood	☐ Y ☐ N	Anxious Mood/Worry
☐ Y ☐ N	Fatigue/ Lack of energy/ Sleeping issues	☐ Y ☐ N	Nightmares/ Flashbacks/ Intrusive thoughts
☐ Y ☐ N	Social withdrawal/ Isolation	☐ Y ☐ N	Anger outburst/ Loss of temper
☐ Y ☐ N	Diminished interest in activities	☐ Y ☐ N	Argues, defies rules and/or adult requests
☐ Y ☐ N	Feelings of hopelessness/ worthlessness	☐ Y ☐ N	Blames others for own mistakes
☐ Y ☐ N	Irritability	☐ Y ☐ N	Cruelty to animals and/or destruction of property
☐ Y ☐ N	Past or Current: Suicidal thoughts and/or attempts	☐ Y ☐ N	Difficulty organizing tasks/ activities
☐ Y ☐ N	Self-harm (cutting, burning, scratching, hitting self, etc.)	☐ Y ☐ N	Easily distracted/ not paying attention
☐ Y ☐ N	Racing thoughts	☐ Y ☐ N	Impulsive Behaviors
☐ Y ☐ N	Hyperactive/ Can't sit still/ Fidgets/ Leaves seat at school	☐ Y ☐ N	Paranoid feelings and/or thoughts
☐ Y ☐ N	Forgetful (due to distracted thoughts)	☐ Y ☐ N	Hallucinations: auditory and/or visual

Any additional symptoms or information you wish to share:

_____

_____

_____

CAGE: *Please check YES or NO*

1. Have you ever felt a need to cut down on drinking or drug use? ☐ YES ☐ NO
2. Have you ever been annoyed by criticism of your drinking? ☐ YES ☐ NO
3. Have you ever had guilty feelings about drinking or drug use? ☐ YES ☐ NO
4. Have you ever taken a morning eye opener? ☐ YES ☐ NO

_____ _____

Client Signature Date

_____ _____

Therapist Signature/ Credentials Date

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☐ Initial
☐ Update (recommended annually)

Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS)
Addendum 2 – Health Risk Assessment (HRA)

21. GENERAL INFORMATION (HRA)

First Name:	Last Name:	Chosen/Preferred Name:	Pronouns:	RIN:

Date of Birth:	Sex at Birth:	Gender Identity:	Height: _____ ft. _____ in.	Weight: _____ lbs.	Date of Last Physical Exam: _____ ☐ Visit due

22. MEDICATION(S)
List current and previous medications below, including over-the-counter medications. Attach additional pages as needed.

Is the customer currently taking any psychotropic medications? ☐ Yes ☐ No

Medication Name	Prescriber	Dosage	Date Started	Date Ended	Medication Side Effects

23. HEALTH STATUS

a. Does the customer have any allergies? ☐ Yes ☐ No If yes, list: _____
b. Does the customer want help to quit smoking? ☐ Yes ☐ No ☐ N/A – does not smoke
c. Has the customer fallen in the past 12 months? ☐ Yes ☐ No ☐ N/A – age under 50

REPRODUCTIVE HEALTH: *(skip to next section if the customer does not have periods)*

a. Does the customer see a reproductive health provider (i.e. OB/GYN)? ☐ Yes - date of last visit: _____ ☐ No - referral needed
b. Is the customer experiencing any issues related to their menstrual cycle or menopause? ☐ Yes ☐ No
   If **yes**, describe. _____
c. Has the customer ever been pregnant? ☐ Yes – currently ☐ Yes – previously ☐ No
   If **yes**, describe the status or the outcome of the pregnancy. _____
d. Has the customer ever been diagnosed with an STD/STI? ☐ Yes ☐ No ☐ Unknown
   If **yes**, is a referral for specialized care needed? ☐ Yes ☐ No ☐ Unknown

CHRONIC PAIN: Does the customer experience chronic pain or complain of pain frequently? ☐ Yes ☐ No *(if **NO**, skip this section)*

a. Has the customer ever taken or been prescribed medication for pain? ☐ Yes ☐ No
   If **yes,** indicate the type: ☐ Cannabis ☐ Opioids ☐ Other (list): _____
b. Describe the location and intensity of the pain. _____

BLOOD SUGAR/DIABETES:

a. Does the customer urinate more frequently than appears normal? ☐ Yes ☐ No
b. Does the customer seem to have an increased thirst compared to others in the same age range? ☐ Yes ☐ No
c. Is the customer compliant with any dietary restrictions related to their blood sugar? ☐ Yes ☐ No ☐ N/A
   If **yes**, describe: _____
d. What was the customer's last tested A1C level? ☐ N/A A1C level: _____ Date of A1C test: _____

ADDITIONAL RELEVANT HEALTH INFORMATION:

24. DEVELOPMENTAL HISTORY *(skip to the next section if the customer is 21 years of age or older)*

a. Was the customer's birth premature? ☐ Yes ☐ No ☐ Unknown

b. Was the customer exposed to the mother's use of tobacco, alcohol, or street/prescription drugs during pregnancy?
☐ Yes (describe below) ☐ No ☐ Unknown

c. Were there any unusual issues related to the mother's labor and delivery?
☐ Yes (describe below) ☐ No ☐ Unknown

Supporting Information: Provide additional information on the customer's social/developmental history, including significant events in prenatal/birth/early childhood stages, enduring physical/medical conditions, and pervasive developmental or cognitive difficulties.

25. MEDICAL HISTORY

How many times has the customer been to the Emergency Room in the past 12 months?
☐ 0 times ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4+ times

What was the reason for the ER visit(s)?

Has the customer ever been psychiatrically hospitalized?
☐ No ☐ Yes (*If **YES**, please describe below. Attach additional pages as needed.)*

Has the customer ever been medically hospitalized?
☐ No ☐ Yes (*If **YES**, please describe below. Attach additional pages as needed.)*

Supporting Information: Describe any other significant medical problems, treatments, hospitalizations, and outcomes not addressed above.