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.

Devereux Early Childhood Assessment for Toddlers Record Form (18 months up to 36 months)

Mary Mackrain, Paul LeBuffe and Gregg Powell

Toddler's Name _____ Gender _____ DOB _____ Age _____ (In Months)

Person Completing this Form _____ Relationship to Toddler _____

Date of Rating _____ Site/Program _____ Room _____

This form describes a number of behaviors seen in some toddlers. Read the statements that follow the phrase: ***During the past 4 weeks, how often did the toddler…*** and place a check mark in the box underneath the word that tells how often you saw the behavior. Answer each question carefully. There are no right or wrong answers. Please answer every item. If you wish to change your answer, put an X through it and fill in your new choice as shown to the right.

Never	Rarely	Occasionally	Frequently	Very Frequently
☒	☑	☐	☐	☐

Item #	*During the past 4 weeks, how often did the toddler…*	Never	Rarely	Occasionally	Frequently	Very Frequently
1	enjoy interacting with others?	☐	☐	☐	☐	☐
2	show affection for a familiar adult?	☐	☐	☐	☐	☐
3	adjust to changes in routine?	☐	☐	☐	☐	☐
4	seek comfort from familiar adults?	☐	☐	☐	☐	☐
5	makes needs known to a familiar adult?	☐	☐	☐	☐	☐
6	act happy with familiar adults?	☐	☐	☐	☐	☐
7	show interest in her/his surroundings?	☐	☐	☐	☐	☐
8	respond when spoken to?	☐	☐	☐	☐	☐
9	show concern for other children?	☐	☐	☐	☐	☐
10	try to comfort others?	☐	☐	☐	☐	☐
11	act happy when praised?	☐	☐	☐	☐	☐
12	participate in group activities?	☐	☐	☐	☐	☐
13	make eye contact with others?	☐	☐	☐	☐	☐
14	enjoy being cuddled?	☐	☐	☐	☐	☐
15	smile back at a familiar adult?	☐	☐	☐	☐	☐
16	ask to do new things?	☐	☐	☐	☐	☐
17	reach for a familiar adult?	☐	☐	☐	☐	☐
18	respond to her/his name?	☐	☐	☐	☐	☐
19	react to another child's cry?	☐	☐	☐	☐	☐
20	smile at familiar adults?	☐	☐	☐	☐	☐
21	easily go from one activity to another?	☐	☐	☐	☐	☐
22	show pleasure when interacting with adults?	☐	☐	☐	☐	☐
23	handle frustration well?	☐	☐	☐	☐	☐
24	makes others aware of her/his needs?	☐	☐	☐	☐	☐
25	accept comfort from a familiar adult?	☐	☐	☐	☐	☐
26	play make-believe?	☐	☐	☐	☐	☐
27	follow simple directions?	☐	☐	☐	☐	☐
28	show preference for a particular playmate?	☐	☐	☐	☐	☐
29	try to clean up after herself/himself?	☐	☐	☐	☐	☐
30	easily follow a daily routine?	☐	☐	☐	☐	☐
31	play with other children?	☐	☐	☐	☐	☐
32	try to do things for herself/himself?	☐	☐	☐	☐	☐
33	calm herself/himself?	☐	☐	☐	☐	☐
34	accept another choice when the first choice was not available?	☐	☐	☐	☐	☐
35	have regular sleeping patterns?	☐	☐	☐	☐	☐
36	express a variety of emotions (e.g. happy, sad, mad)?	☐	☐	☐	☐	☐