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: _____				

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

ILLINOIS DEPARTMENT OF Healthcare and Family Services

☐ Initial
☐ 12 month re-assessment
☐ Discharge

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

Addendum 1 – Health Risk Assessment (HRA)

Please note: This assessment must be completed for all individuals once every 12 months.

18. GENERAL INFORMATION (HRA)

Staff Name:	Individual First and Last Name:	RIN:	Date of Birth:	Gender:

Height: _____ ft. _____ in.	Weight: _____ lbs.	Primary Care Doctor's Name:	Date of Last Physical Exam: _____ ☐ Visit due	Date of Last Flu Shot: _____

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

Is the individual currently taking any psychotropic medications? ☐ Yes ☐ No **CANS Rating – Medication Compliance:** _____

If **yes**, does the individual regularly receive lab work? ☐ Yes ☐ No ☐ Not required ☐ Unknown

Medication Name	Prescriber	Dosage	Date Started	Date Ended	Medication Issues

20. HEALTH STATUS

CANS Rating – Medical/Physical: _____

a. Individual's self-report on general physical health:
☐ Excellent ☐ Good ☐ Fair ☐ Poor

b. How many snack foods or drinks (e.g., chips, cookies, candy, soda) does the individual usually consume in a day?
☐ 0-1 ☐ 2-3 ☐ More than 4

c. How many servings of fruits and vegetables does the individual usually eat in a day?
☐ 0-1 ☐ 2-3 ☐ More than 4

d. Does the individual engage in physical activity? ☐ Yes ☐ No
If **yes**, how often? _____

e. Does the individual use any form of tobacco? ☐ Yes ☐ No

f. Does the individual drink alcohol?
If **yes**, how often and how much? _____

g. Has the individual ever fainted or passed out? ☐ Yes ☐ No
If **yes**, describe: _____

h. Does the individual have any allergies? ☐ Yes ☐ No
If **yes**, list: _____

i. Has the individual fallen in the past 12 months? ☐ Yes ☐ No
If **yes**, describe: _____

j. Does the individual want help to quit smoking? ☐ Yes ☐ No ☐ N/A

HEALTH CONCERNS: Does the individual have any current health concerns? ☐ Yes ☐ No If **yes**, describe below.

GENERAL ILLNESS: Does the individual have a tendency to any illnesses ☐ Yes ☐ No If **yes**, describe below.

BREATHING ISSUES: Does the individual have any trouble breathing?
☐ Yes ☐ No *(if **NO**, skip to next section)*

a. What are the breathing issues related to? Check all that apply.
☐ Physical activity ☐ Weather extremes ☐ Other: _____

b. Does the individual take medication for breathing issues?
☐ Yes ☐ No

COGNITIVE ASSESSMENT: *(skip if the individual is **under age 50**)*

a. Has the individual ever had a significant head injury? ☐ Yes ☐ No
If **yes**, when? _____

b. Does the individual have any difficulty remembering or recalling events?
☐ Yes ☐ No

c. Can the individual correctly tell you what year, month, and day it is?
☐ Yes ☐ No

BLOOD SUGAR/DIABETES:

a. Does the individual urinate more frequently than appears normal? ☐ Yes ☐ No

b. Does the individual seem to have an increased thirst, compared to others in the same age range? ☐ Yes ☐ No

c. Does the individual have any special dietary instructions related to his/her blood sugar? ☐ Yes ☐ No
If **yes**, describe: _____

d. Does the individual take any medication to control his/her blood sugar? ☐ Yes ☐ No

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

a. Has the individual 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. _____

SEXUAL RISK BEHAVIORS: Is the individual sexually active?
☐ Yes ☐ No (*if **NO,** skip to next section)*

a. Does the individual use any protection against sexually transmitted diseases/infections (STDs/STIs) when engaged in sexual activity?
☐ Yes ☐ Sometimes ☐ No

c. When was the individual last tested for STDs/STIs? _____

d. Has the individual ever been diagnosed with an STD/STI or HIV?
☐ Yes ☐ No
If **yes**, list the diagnosis and the age of occurrence. _____

FEMALE REPRODUCTIVE HEALTH: *(if the individual is a **male**, or if the **female has not had her first period**, skip to next section)*

a. Does the individual see a women's health provider?
☐ Yes - date of last visit: _____ ☐ No – referral needed

b. Is the individual experiencing any issues related to her menstrual cycle or menopause? ☐ Yes ☐ No
If **yes**, describe. _____

c. Is the individual currently or has the individual ever been pregnant?
☐ Yes – currently ☐ Yes – previously ☐ No
If **yes**, describe the status or the outcome of the pregnancy.

21. DEVELOPMENTAL HISTORY

Complete this section based on the individual's early childhood experiences.

a. Did the individual's mother receive the appropriate prenatal care?
☐ Yes ☐ No ☐ Unknown

b. Were there any complications during the mother's pregnancy?
☐ Yes (describe below) ☐ No ☐ Unknown

c. Was the individual's birth normal or premature?
☐ Normal ☐ Premature ☐ Unknown

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

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

f. What was the individual's birth weight? _____

g. When did the individual first crawl? _____ Walk? _____ Talk? _____

h. When did the individual begin toilet training? _____

i. Does the individual have a biological parent or sibling that has developmental or behavioral problems?
☐ Yes ☐ No ☐ Unknown

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

22. MEDICAL HISTORY

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

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

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

Hospital Name	Location (City, State)	Dates Hospitalized	Reason(s)

List all additional hospitalizations the individual has experienced. Attach additional pages as needed. ☐ N/A

Hospital Name	Location (City, State)	Dates Hospitalized	Reason(s)

List the names and specialties of the providers currently providing medical treatment to the individual. Attach additional pages as needed.

Provider Name	Specialty	Service(s) Provided

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