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**Comprehensive Community Services (CCS) Comprehensive Assessment**

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| **Consumer’s Name:**  | Name | **Consumer ID #:**  | ID # |
| **Date of Birth:**  | DOB | **Service Facilitator:**  | Name |
| **Date of Application for CCS:**  | Date | **Assessment Completion Date:** | Date |

**Instructions:** The comprehensive assessment, assessment summary, 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.

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| **Life satisfaction** |
| 1. **What aspects of your life do you like or see as strengths?**  Consumer Comments
2. **When was the last time you had a good day? What made it a good day?** Consumer Comments
3. **What happens in a typical day for you?** Consumer Comments
4. **What do you do for fun?** Consumer Comments
5. **What aspects of your life do you like?** Consumer Comments

**What would you change if you could?** Consumer Comments**Is this an area you would like to work on as an area of intervention?** [ ]  Yes [ ]  Not at this time**If so, what are your priorities or goals in this area?** Consumer Comments**Additional comments or notes:** Additional comments or notes, including possible options for treatment, Psychosocial Rehabilitation Services (PRS), and self-help programs to address the consumer’s priorities or goals. Address any applicable age or developmental factors.  |
| **Domain Review and Updates** (at least every 6 months) |
| Date | Update (may include barriers, consumer and team discussion, consumer satisfaction with services) |
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| **Basic needs**  |
| 1. **Basic needs include things like food, shelter, and safety. Are there other things you consider your “basic needs”?** Consumer Comments
2. **Do you feel your basic needs are met?** Consumer Comments
3. **What basic needs are not being met?** Consumer Comments

**Is this an area you would like to work on as an area of intervention?** [ ]  Yes [ ]  Not at this time**If so, what are your priorities or goals in this area?** Consumer Comments**Additional comments or notes:** Additional comments or notes, including possible options for treatment, Psychosocial Rehabilitation Services (PRS), and self-help programs to address the consumer’s priorities or goals. Address any applicable age or developmental factors.  |
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| **Social network and family involvement**  |
| 1. **Do you have family members who are supportive of you; if so, how do they support you?** Consumer Comments
2. **Describe your relationship with family members.** Consumer Comments
3. **Who else is supportive of you?** (e.g. friends, neighbors, colleagues at work, religious/spiritual community, other cultural or environmental supports) Consumer Comments
4. **Are there any cultural or language barriers that inhibit your social involvement?** Consumer Comments

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| **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:* |

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| **Community Living Skills Overview-** **\*\* All these are part of the Functional Screen** | **Strength** | **Need** | **Not a Need** | **Consumer Priority?****YES NO** | **Comments** |
| Benefit/Resource Management (Access, Navigate, etc) |  |  |  |  |  |  |
| Basic Safety (recognize dangerous situations and respond in emergency) |  |  |  |  |  |  |
| Social or Interpersonal Skills (Effectively interact with adults) |  |  |  |  |  |   |
| Home Hazards (Maintain basic living environment to avoid disease hazards, fire hazards and odors noticeable from outside) |  |  |  |  |  |  |
| Money Management (Manage finances for basic needs, pays bills, budget, etc) |  |  |  |  |  |  |
| Basic Nutrition (Maintain eating schedule, obtain groceries, prepares simple meals and avoids spoils foods) |  |  |  |  |  |  |
| General Health Maintenance (can care for own health and recognize symptoms. Makes and keeps medical appointments |  |  |  |  |  |  |
| Manages Psychiatric symptoms (can manage mental health symptoms- hallucinations, delusions, mania, thought disorders, etc.) |  |  |  |  |  |  |
| Hygiene and Grooming |  |  |  |  |  |  |
| Taking Medication (Medication administration and assisting with self-administration, with setup, reminders, cueing, and observation to ensure person takes medication) |  |  |  |  |  |  |
| Monitoring Medication Effects (recognize effects and noticeable side effects, report to provider and follow medication recommendations) |  |  |  |  |  |  |
| Transportation (Needs assistance to arrange for, use or maintain vehicle) |  |  |  |  |  |  |
| Physical Assistance with ADL’s |  |  |  |  |  |  |
| 1. **What do you see as your areas of strength in this area (these may be things you do well/independently, or things you are receiving assistance in that you are satisfied with)?** Consumer Comments
2. **What areas do you need or want assistance with (or what areas are you receiving assistance with for which you are not satisfied)?** Consumer Comments

**Is this an area you would like to work on as an area of intervention?**  [ ]  Yes [ ]  Not at this time**If so, what are your priorities or goals in this area?** Consumer Comments**Additional comments or notes:** Additional comments or notes, including possible options for treatment, Psychosocial Rehabilitation Services (PRS), and self-help programs to address the consumer’s priorities or goals. Address any applicable age or developmental factors.  |
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| **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. **Are you happy in your current home?** Consumer Comments
2. **Are there any barriers to continuing to live in your current home?** Consumer Comments
3. **If you aren’t happy in your current home, what changes in your living situation you would like to make?** Consumer Comments

**Is this an area you would like to work on as an area of intervention?** [ ]  Yes [ ]  Not at this time**If so, what are your priorities or goals in this area?** Consumer Comments**Additional comments or notes:** Additional comments or notes, including possible options for treatment, Psychosocial Rehabilitation Services (PRS), and self-help programs to address the consumer’s priorities or goals. Address any applicable age or developmental factors.  |
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| **Employment, Finances, and Benefits** |
| *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?** [ ]  Yes [ ]  Not at this time [ ]  I am a student

 ***If “Yes”:*** |
| 1. **Where do you work?** Consumer Comments
2. **Do you like your current job; if not, what about it don’t you like?** Consumer Comments
3. **Do you have benefits such as paid time off, retirement, and/or health insurance?** Consumer Comments**Is your current income adequate to meet your needs?** Consumer Comments
 |
| ***If “Not at this time”:*** |
| 1. **Do you want to be employed?** Consumer Comments
2. **Are you currently looking for employment?** Consumer Comments
3. **What skills do you have that you think would be useful in a job?** Consumer Comments
4. **What was that last job that you had that you liked?** Consumer Comments
5. **What type of income do you need or want?** Consumer Comments
6. **What type of benefits to you need or want?** Consumer Comments
 |
| **Is this an area you would like to work on as an area of intervention?** [ ]  Yes [ ]  Not at this time**If so, what are your priorities or goals in this area?** Consumer Comments**Additional comments or notes:** Additional comments or notes, including possible options for treatment, Psychosocial Rehabilitation Services (PRS), and self-help programs to address the consumer’s priorities or goals. Address any applicable age or developmental factors.  |
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| **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 and consider the following questions:* |
| 1. **What are your (or your child’s) education strengths; what is he or she good at?** Consumer Comments
2. **Are there any areas of concern (academic, behavioral, attendance)?** Consumer Comments
 |
| *If the consumer is an* ***adult****, please refer to the* ***Vocational Information*** *section of their Functional Eligibility Screen and consider the following questions:* |
| 1. **Are you currently involved in or seeking continuing education or training?** Consumer Comments
2. **If not, are you interested in doing so?** Consumer Comments

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| **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:* |
| 1. **Current mental health diagnosis(es):** Diagnosis(es)
2. **Please describe how your mental or behavioral health symptoms affect you in your daily life:** Consumer Comments
3. **What do you do to manage your mental health symptoms?** Consumer Comments
4. **Who are your current mental health providers; are they helpful to you?** Consumer Comments

**Is this an area you would like to work on as an area of intervention?** [ ]  Yes [ ]  Not at this time**If so, what are your priorities or goals in this area?** Consumer Comments**Additional comments or notes:** Additional comments or notes, including possible options for treatment, Psychosocial Rehabilitation Services (PRS), and self-help programs to address the consumer’s priorities or goals. Address any applicable age or developmental factors.  |
| **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 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

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| **Mental Status Exam** |
| The following is required to be included in the consumer’s medical record per (DHS 106.02[9][b], Wis. Admin. Code). [ ]  Mental status exam, including mood and affect, thought processes — principally orientation X3, dangerousness to others and self, and behavioral and motor observations. Other information that may be essential depending on presenting symptoms includes thought processes other than orientation X3, attitude, judgment, memory, speech, thought content, perception, intellectual functioning, and general appearance (clinical findings and/or diagnosis or medical impression). |
| **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 have any unmet needs in this area?** Consumer Comments
2. **Who are your current health care providers; are they helpful to you?** Consumer Comments

 **Is this an area you would like to work on as an area of intervention?** [ ]  Yes [ ]  Not at this time**If so, what are your priorities or goals in this area?** Consumer Comments**Additional comments or notes:** Additional comments or notes, including possible options for treatment, Psychosocial Rehabilitation Services (PRS), and self-help programs to address the consumer’s priorities or goals. Address any applicable age or developmental factors.  |
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| **Reproductive Life Plan** |
| ***The goal of the One Key Question® Pilot is to prevent unintended pregnancy, promote preconception care, and support an individual’s needs for healthy pregnancies and thriving births.*** *Use the information as a base for discussion and consider the following questions:*1. **Would you like to become pregnant in the next year?** [ ]  Yes [ ]  No [ ]  OK either way[ ]  Unsure

Consumer Comments1. **Do you hope to have any (more) children?** [ ]  Yes [ ]  No [ ]  OK either way[ ]  Unsure

Consumer Comments1. **How many children do you hope to have?** Consumer Comments
2. **When would you plan your child/children?** Consumer Comments

1. **What do you plan to do until you (and your partner) are ready to have a baby?** Consumer Comments
2. **What can I do today to help you achieve your plan?** Consumer Comments

1. **May I help assist you with a referral to our Public Health (PH) Clinic?** [ ]  Yes [ ]  No [ ]  OK either way[ ]  Unsure Consumer Comments

**Follow up for Service Facilitators**1. ***Did you make an appointment with consumer present?*** [ ]  *Yes* [ ]  *No*
2. ***Did you receive results returned from Public Heath or private physician?*** [ ]  *Yes* [ ]  *No*
3. ***Did you make a “priority appointment” with consumer present?*** [ ]  *Yes* [ ]  *No*
4. ***Was there a change in psychotropic medications after being asked OKQ?*** [ ]  *Yes* [ ]  *No*
5. ***Did consumer go from no contraception to a form of contraception after being asked OKQ?*** [ ]  *Yes* [ ]  *No* ***What form of contraception?*** Consumer Comments
6. ***Was folic acid initiated after being asked OKQ?*** [ ]  *Yes* [ ]  *No*
 |
| **Is this an area you would like to work on as an area of intervention?** [ ]  Yes [ ]  No [ ]  OK either way[ ]  Unsure Consumer Comments **If so, what are your priorities or goals in this area?** Consumer Comments**Additional comments or notes:** Additional comments or notes, including possible options for treatment, Psychosocial Rehabilitation Services (PRS), and self-help programs to address the consumer’s priorities or goals. Address any applicable age or developmental factors.  |

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| **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:*1. **Do you take medications to help to help monitor your mental, behavioral, or physical health symptoms?** [ ]  Yes [ ]  Not at this time
2. **If so, do you find them helpful? (please explain):** Consumer Comments
3. **Do any side effects really bother you?** Consumer Comments
4. **If not, are you interested in medication as a treatment option?** Consumer Comments

**Is this an area you would like to work on as an area of intervention?** [ ]  Yes [ ]  Not at this time**If so, what are your priorities or goals in this area?** Consumer Comments**Additional comments or notes:**  Additional comments or notes, including possible options for treatment, Psychosocial Rehabilitation Services (PRS), and self-help programs to address the consumer’s priorities or goals. Address any applicable age or developmental factors.  |
| ***Current Prescribed Medications*** |
| 1. Name/Dose/Frequency | Prescribing Physician |
| Purpose: PurposeRoute of Administration: Route of AdministrationDate the medication is to be stopped: Date medication is to be stoppedNotes: Consumer perspective on effectiveness, side effects, any issues, etc. |
| 2. Name/Dose/Frequency | Prescribing Physician |
| Purpose: PurposeRoute of Administration: Route of AdministrationDate the medication is to be stopped: Date medication is to be stoppedNotes: Consumer perspective on effectiveness, side effects, any issues, etc. |
| 3. Name/Dose/Frequency | Prescribing Physician |
| Purpose: PurposeRoute of Administration: Route of AdministrationDate the medication is to be stopped: Date medication is to be stoppedNotes: Consumer perspective on effectiveness, side effects, any issues, etc. |
| 4. Name/Dose/Frequency | Prescribing Physician |
| Purpose: PurposeRoute of Administration: Route of AdministrationDate the medication is to be stopped: Date medication is to be stoppedNotes: Consumer 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
 | Purpose, effectiveness, side effects, how long taken, any issues, etc. |
| 1. Name/Dose/Frequency
 | Purpose, effectiveness, side effects, how long taken, any issues, etc. |
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 | Purpose, effectiveness, side effects, how long taken, any issues, etc. |
| *If there are additional over the counter medications, please attach the information.* |
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| **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:* |
| 1. **Do you believe use of substances interferes with any part of your life?** Consumer Comments
2. **If so, are you able to talk to anyone about this; why or why not?** Consumer Comments
3. **Have you ever participated in a professional substance use assessment or treatment?** Consumer Comments
4. **Have you used substances other than those required for medical reasons?** Consumer Comments
5. **Do you abuse more than one substance at a time?** Consumer Comments
6. **Are you always able to stop using substances when you want to?** Consumer Comments
7. **Have you had “blackouts” or “flashbacks” as a result of your substance use?** Consumer Comments
8. **Do you ever feel bad or guilty about your substance use?** Consumer Comments
9. **Does your spouse (or family members) ever complain about your involvement with substances?** Consumer Comments
10. **Have you neglected your family because of your use of substances?** Consumer Comments
11. **Have you engaged in illegal activities in order to obtain substances?** Consumer Comments
12. **Have you ever experienced withdrawal symptoms (felt sick) when you stopped using substances**? Consumer Comments
13. **Have you had any medical problems as a result of your drug use (memory loss, injury, etc.)?** Consumer 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 |  |  |  |  |  |

**Is this an area you would like to work on as an area of intervention?** [ ]  Yes [ ]  Not at this time

**If so, what are your priorities or goals in this area?** Consumer Comments

**Additional comments or notes:** Additional comments or notes, including possible options for treatment, Psychosocial Rehabilitation Services (PRS), and self-help programs to address the consumer’s priorities or goals. Address any applicable age or developmental factors.

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| **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?** Consumer Comments
2. **When you’re stressed, who or what calms you?** Consumer Comments
3. **Have you experienced any of the following at any time in your life?**
4. **Witnessed someone seriously injured or killed due to an unnatural event such as a shooting or auto accident?**  [ ]  Yes [ ]  No [ ]  Not Sure Consumer Comments
5. **Experienced a natural disaster, severe accident, or threat to your life?** [ ]  Yes [ ]  No [ ]  Not Sure Consumer Comments
6. **Had a child/loved one experience a serious medical, mental health, or developmental setback?** [ ]  Yes [ ]  No [ ]  Not Sure Consumer Comments
7. **Witnessed a physical or sexual assault against a family member or significant person?** [ ]  Yes [ ]  No [ ]  Not Sure Consumer Comments
8. **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 Comments
9. **Has anyone slapped, pushed, grabbed, shoved, choked, kicked, bit, or punched you?** [ ]  Yes [ ]  No [ ]  Not Sure Consumer Comments
10. **Been threatened with, or actually used a knife, gun, or other weapon to scare or harm you?** [ ]  Yes [ ]  No [ ]  Not Sure Consumer Comments
11. **Been afraid that a specific person (known to you well or not) would harm you physically?** [ ]  Yes [ ]  No [ ]  Not Sure Consumer Comments
12. **Are there other events in your life that have been traumatic for you?** [ ]  Yes [ ]  No [ ]  Not Sure Consumer Comments

***If the answer to any part of this question is “Yes” or “Not Sure”, please continue with question 4, otherwise go on to question 5.*** 1. **Have you experienced any of the following: flashbacks, nightmares, significant anxiety, or intrusive thoughts related to your traumatic experience(s)?**  [ ]  Yes [ ]  No Consumer Comments

**Is this an area you would like to work on as an area of intervention?** [ ]  Yes [ ]  Not at this time**If so, what are your priorities or goals in this area?** Consumer Comments**Additional comments or notes:** Additional comments or notes, including possible options for treatment, Psychosocial Rehabilitation Services (PRS), and self-help programs to address the consumer’s priorities or goals. Address any applicable age or developmental factors.  |
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| **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 (if any) crisis situations have occurred in the past?** Consumer Comments
2. **Who or what have you turned to in a crisis situation (what interventions have been tried)?** Consumer Comments
	1. **Which of these have worked/been successful?** Consumer Comments
	2. **What haven’t worked/been unsuccessful?** Consumer Comments

**Is this an area you would like to work on as an area of intervention?** [ ]  Yes [ ]  Not at this time**If so, what are your priorities or goals in this area?** Consumer Comments**Additional comments or notes:** Additional comments or notes, including possible options for treatment, PRS, and self-help programs to address the consumer’s priorities or goals. Address any applicable age or developmental factors. |
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| **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. **Please describe any current legal involvement or issues that may be affecting you. (Examples: divorce and/or child custody process, bankruptcy, mortgage foreclosure, pending criminal charges, restraining order)** Consumer’s Comments

**Is this an area you would like to work on as an area of intervention?** [ ]  Yes [ ]  Not at this time**If so, what are your priorities or goals in this area?** Consumer Comments**Additional comments or notes:** Additional comments or notes, including possible options for treatment, Psychosocial Rehabilitation Services (PRS), and self-help programs to address the consumer’s priorities or goals. Address any applicable age or developmental factors.  |
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| Date | Update (may include barriers, consumer and team discussion, consumer satisfaction with services) |

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| **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 Comments
2. **Are there any additional areas of need or barriers that you would like to discuss?** Consumer Comments
	1. **If so, what are your priorities or goals in this area?** Consumer Comments
3. **Additional comments or notes:** Additional comments or notes, including possible options for treatment, Psychosocial Rehabilitation Services (PRS), and self-help programs to address the consumer’s priorities or goals. Address any applicable age or developmental factors.

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|  **Domain Review and Updates** (at least every 6 months) |
| Date | Update (may include barriers, consumer and team discussion, consumer satisfaction with services) |
| Date | Update (may include barriers, consumer and team discussion, consumer satisfaction with services) |
| Date | Update (may include barriers, consumer and team discussion, consumer satisfaction with services) |
| Date | Update (may include barriers, consumer and team discussion, consumer satisfaction with services) |

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| **Signatures** |
|  |
| **Individuals Participating in the Assessment** | **Relationship to the Consumer** | **Meeting Dates / Dates participating in the Assessment** | **Signature***The assessment process was explained to me, and I was part of the assessment process.* | **Signature Date** |
| Consumer | Relationship | Dates |  |  |
| Parent/Guardian | Relationship | Dates |  |  |
| Service Facilitator | Relationship | Dates |  |  |
| Mental Health Professional | Relationship | Dates |  |  |
| Other Support | Relationship | Dates |  |  |
| Other Support | Relationship | Dates |  |  |