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

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| **Consumer’s Name:**  | Consumer’s Name | **Consumer ID #:**  | Consumer ID # |
| **Date of Birth:**  | Date of Birth | **Service Facilitator:**  | Service Facilitator |
| **Date of Application for CCS:**  | Application 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’s Comments
2. **When was the last time you had a good day? What made it a good day?** Consumer’s Comments
3. **What happens in a typical day for you?** Consumer’s Comments
4. **What do you do for fun?** Consumer’s Comments
5. **What aspects of your life do you like?** Consumer’s Comments

**What would you change if you could?** 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’s 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. |
| **Basic needs**  |
| 1. **Basic needs include things like food, shelter, and safety. Are there other things you consider your “basic needs”?** Consumer’s Comments
2. **Do you feel your basic needs are met?** Consumer’s Comments
3. **What basic needs are not being met?** 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’s 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. |
| **Social network and family involvement**  |
| 1. **Do you have family members who are supportive of you; if so, how do they support you?** Consumer’s Comments
2. **Describe your relationship with family members.** Consumer’s Comments
3. **Who else is supportive of you?** (e.g. friends, neighbors, colleagues at work, religious/spiritual community, other cultural or environmental supports) Consumer’s Comments
4. **Are there any cultural or language barriers that inhibit your social involvement?** 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’s 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. |
| **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:* |
| 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’s 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’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’s 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. |
| **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’s Comments
2. **Are there any barriers to continuing to live in your current home?** Consumer’s Comments
3. **If you aren’t happy in your current home, what changes in your living situation you would like to make?** 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’s 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. |
| **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’s Comments
2. **Do you like your current job; if not, what about it don’t you like?** Consumer’s Comments
3. **Do you have benefits such as paid time off, retirement, and/or health insurance?** Consumer’s Comments**Is your current income adequate to meet your needs?** Consumer’s Comments
 |
| ***If “Not at this time”:*** |
| 1. **Do you want to be employed?** Consumer’s Comments
2. **Are you currently looking for employment?** Consumer’s Comments
3. **What skills do you have that you think would be useful in a job?** Consumer’s Comments
4. **What was that last job that you had that you liked?** Consumer’s Comments
5. **What type of income do you need or want?** Consumer’s Comments
6. **What type of benefits to you need or want?** Consumer’s Comments
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| **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’s 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. |
| **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’s Comments
2. **Are there any areas of concern (academic, behavioral, attendance)?** Consumer’s 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’s Comments
2. **If not, are you interested in doing so?** 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’s 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.  |
| **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):** Diagnoses
2. **Please describe how your mental or behavioral health symptoms affect you in your daily life:** Consumer’s Comments
3. **What do you do to manage your mental health symptoms?** Consumer’s Comments
4. **Who are your current mental health providers; are they helpful to you?** 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’s 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. |
| **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** |
| **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. |

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| **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’s Comments
2. **Who are your current health care providers; are they helpful to you?** 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’s 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. |
| **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’s Comments
3. **Do any side effects really bother you?** Consumer’s Comments
4. **If not, are you interested in medication as a treatment option?** 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’s 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. |
| ***Current Prescribed Medications*** |
| 1. Name/Dose/Frequency | Prescribing Physician |
| Purpose: PurposeNotes: Consumer’s perspective on effectiveness, side effects, any issues, etc. |
| 2. Name/Dose/Frequency | Prescribing Physician |
| Purpose: PurposeNotes: Consumer’s perspective on effectiveness, side effects, any issues, etc. |
| 3. Name/Dose/Frequency | Prescribing Physician |
| Purpose: PurposeNotes: Consumer’s perspective on effectiveness, side effects, any issues, etc. |
| 4. Name/Dose/Frequency | Prescribing Physician |
| Purpose: PurposeNotes: 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
 | Purpose, effectiveness, side effects, how long taken, any issues, etc. |
| 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. |
| 1. Name/Dose/Frequency
 | Purpose, effectiveness, side effects, how long taken, any issues, etc. |
| *If there are additional over the counter medications, please attach the information.* |
| **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’s Comments
2. **If so, are you able to talk to anyone about this; why or why not?** Consumer’s Comments
3. **Have you ever participated in a professional substance use assessment or treatment?** Consumer’s Comments
4. **Have you used substances other than those required for medical reasons?** Consumer’s Comments
5. **Do you abuse more than one substance at a time?** Consumer’s Comments
6. **Are you always able to stop using substances when you want to?** Consumer’s Comments
7. **Have you had “blackouts” or “flashbacks” as a result of your substance use?** Consumer’s Comments
8. **Do you ever feel bad or guilty about your substance use?** Consumer’s Comments
9. **Does your spouse (or family members) ever complain about your involvement with substances?** Consumer’s Comments
10. **Have you neglected your family because of your use of substances?** Consumer’s Comments
11. **Have you engaged in illegal activities in order to obtain substances?** Consumer’s Comments
12. **Have you ever experienced withdrawal symptoms (felt sick) when you stopped using substances**? Consumer’s Comments
13. **Have you had any medical problems as a result of your drug use (memory loss, injury, etc.)?** 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 |  |  |  |  |  |

**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’s 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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| **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’s Comments
2. **When you’re stressed, who or what calms you?** Consumer’s 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’s Comments
5. **Experienced a natural disaster, severe accident, or threat to your life?** [ ]  Yes [ ]  No [ ]  Not Sure Consumer’s Comments
6. **Had a child/loved one experience a serious medical, mental health, or developmental setback?** [ ]  Yes [ ]  No [ ]  Not Sure Consumer’s Comments
7. **Witnessed a physical or sexual assault against a family member or significant person?** [ ]  Yes [ ]  No [ ]  Not Sure Consumer’s 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’s Comments
9. **Has anyone slapped, pushed, grabbed, shoved, choked, kicked, bit, or punched you?** [ ]  Yes [ ]  No [ ]  Not Sure Consumer’s Comments
10. **Been threatened with, or actually used a knife, gun, or other weapon to scare or harm you?** [ ]  Yes [ ]  No [ ]  Not Sure Consumer’s Comments
11. **Been afraid that a specific person (known to you well or not) would harm you physically?** [ ]  Yes [ ]  No [ ]  Not Sure Consumer’s Comments
12. **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 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’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’s 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. |
| **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’s Comments
2. **Who or what have you turned to in a crisis situation (what interventions have been tried)?** Consumer’s Comments
	1. **Which of these have worked/been successful?** Consumer’s Comments
	2. **What haven’t worked/been unsuccessful?** 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’s 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. |
| **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’s 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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| **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
	1. **If so, what are your priorities or goals in this area?** Consumer’s Comments
3. **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.