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

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

**Dates of Completion and Updates:**

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| **Date the assessment process was explained to the consumer:** | Date |

If the assessment process was abbreviated, please select which of the following circumstances applied:

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|  | The consumer's health or symptoms are such that only limited information can be obtained immediately. Notes/Explanation: Enter notes/explanation | | | | |
|  | The consumer chooses not to provide information necessary to complete a comprehensive assessment at the time of application. Notes/Explanation: Enter notes/explanation | | | | |
|  | The consumer is immediately interested in receiving only specified services that require limited information. Notes/Explanation: Enter notes/explanation | | | | |
| Completion date of abbreviated assessment *(if applicable):* | | | | Date |
| Expiration date of abbreviated assessment *(if applicable)*: | | | 3 months from application date | |
| **Completion of comprehensive assessment summary:** | | | Comprehensive Assessment completion date | |
| **Assessment Updates:** | | Dates updated | | |

**Instructions:** The initial assessment process 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.

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| **Historical Summary** | | |
| **What brought you to CCS? What services and supports have been tried in the past?**  Click Here |
| **Life satisfaction** | | |
| **Domain Narrative:** Click Here  **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 | |
| **Basic Needs** | | |
| **Domain Narrative:** Click Here  **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 | |
| **Social Network and Family Involvement** | | |
| **Domain Narrative:** Click Here  **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 | |
| **Community Living Skills** | | |
| **Domain Narrative:** Click Here  **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 | | |

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| **Housing** | | | |
| **Domain Narrative:** Click Here  **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 | | |
| **Employment, Finances, and Benefits** | | | |
| **Domain Narrative:** Click Here  **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 | | |
| **Education** | | | |
| **Domain Narrative:** Click Here  **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 | | | |
| **Mental Health / Behavioral Health** | | | |
|  |  |  |
| **Mental Health Diagnosis(es)** | **Diagnosed By** | **Date of Diagnosis** |
|  |  |  |
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| **Domain Narrative:** Click Here  **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 | | | |
| **Physical Health / Medical** | | | |
| **Domain Narrative:** Click Here  **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 | | | |

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| **Medications** | | | | |
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| **Current Prescribed Medications**  *This information must be in the consumer’s file but does not necessarily have to be included in this assessment summary document (please note below if this is the case).* | | | |
| 1. Name/Dose/Frequency | | | Prescribing Physician |
| Purpose: Purpose  Route of Administration: Route of Administration  Date the medication is to be stopped: Date medication is to be stopped  Notes: Consumer perspective on effectiveness, side effects, any issues, etc. | | |
| 2. Name/Dose/Frequency | | | Prescribing Physician |
| Purpose: Purpose  Route of Administration: Route of Administration  Date the medication is to be stopped: Date medication is to be stopped  Notes: Consumer perspective on effectiveness, side effects, any issues, etc. | | |
| 3. Name/Dose/Frequency | | | Prescribing Physician |
| Purpose: Purpose  Route of Administration: Route of Administration  Date the medication is to be stopped: Date medication is to be stopped  Notes: Consumer perspective on effectiveness, side effects, any issues, etc. | | |
| 4. Name/Dose/Frequency | | | Prescribing Physician |
| Purpose: Purpose  Route of Administration: Route of Administration  Date the medication is to be stopped: Date medication is to be stopped  Notes: Consumer perspective on effectiveness, side effects, any issues, etc. | | |
|  | | | |
| ***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. | |

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| **Domain Narrative:** Click Here  **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 |

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| **Substance Use** | |
| **Domain Narrative:** Click Here  **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 | |
| **Trauma and Significant Life Stressors** | |
| **Domain Narrative:** Click Here  **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 | |
| **Crisis prevention and management** | |
| **Domain Narrative:** Click Here  **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 |
| **Legal Status** | |
| **Domain Narrative:** Click Here  **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 Needs and Strengths** | |
| **Domain Narrative:** Click Here  **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 | |

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| **Domain Summary** | | |
| **Domain** | **Status** |
| Life Satisfaction | Work on it now  Wait/maybe later  No current needs |
| Basic Needs | Work on it now  Wait/maybe later  No current needs |
| Social Network & Family Involvement | Work on it now  Wait/maybe later  No current needs |
| Community Living Skills | Work on it now  Wait/maybe later  No current needs |
| Housing | Work on it now  Wait/maybe later  No current needs |
| Employment, Finances & Benefits | Work on it now  Wait/maybe later  No current needs |
| Education | Work on it now  Wait/maybe later  No current needs |
| Physical Health | Work on it now  Wait/maybe later  No current needs |
| Mental Health | Work on it now  Wait/maybe later  No current needs |
| Medications | Work on it now  Wait/maybe later  No current needs |
| Substance Use | Work on it now  Wait/maybe later  No current needs |
| Trauma & Stressors | Work on it now  Wait/maybe later  No current needs |
| Crisis Prevention & Management | Work on it now  Wait/maybe later  No current needs |
| Legal Status | Work on it now  Wait/maybe later  No current needs |
| Additional Needs & Strengths | Work on it now  Wait/maybe later  No current needs |

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| **Consumer Vision / Criteria for Discharge** |
| **In the Consumer’s own words, what would things be like or how would things be different in their life where they would know they were ready for discharge / transition from CCS:**  Consumer Comments |
| **Assessment Summary Narrative / Diagnostic Formulation** |
| May include information such as presenting issues, predisposing factors (background needs, developmental challenges, trauma history), precipitating factors (what led to the referral), perpetuating factors (ongoing needs or challenges that keep change from happening), protective factors (strengths), and a case for why CCS/clinical services are justified as a medically necessary response. |

**Significant differences of opinion, if any, which are not yet resolved among members of the recovery team:**

The following differences of opinion exist: Click or tap here to enter text.

There are no differences of opinion at this time

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| **Assessment Process Roster** | | | | |
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| **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 |  |  |

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

Assessment \_\_\_ Initial \_\_\_\_ Update

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Service Facilitator Dated

The assessment process was explained to me and reflects my current strengths and needs.

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Consumer Dated

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Parent/Guardian Dated

I have reviewed and attest to this applicant’s need for psychosocial services as set forth in DHS 36 and medical and supportive services to address the desired recovery goals. I am authorizing services per the plan.

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Mental Health Professional Dated

I have reviewed and attest to this applicant’s need for psychosocial services as set forth in DHS 36 and DHS 75 and medical and supportive services to address the desired recovery goals. I am authorizing services per the plan.

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Substance Use Professional Dated