

## Adult Comprehensive Assessment Addendums

This portion of the Adult Comprehensive Assessment Manual contains instructions for completing the Assessment Addendums. It will not be necessary to complete the Addendums for all clients. It is up to the individual agency to determine which programs are required to capture the information contained on the each Addendum.

| Data Field  | Legal Status Addendum   |
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| <b>Rep Payee</b>  | Note if person served has a designated Rep Payee. If so, document Rep Payee's name or name of the agency, phone number and relationship to person served.   |
| <b>Legal Guardian</b>   | Note if person served has a legally appointed guardian. If so, document guardian's name, phone number and relationship to person served. Note <i>Type</i> of guardianship by checking the appropriate box. Also, indicate if it is permanent or temporary by checking the appropriate box. If temporary, provide detail, including the expiration date. |
| <b>Conservatorship</b>  | Note if person served has a Conservatorship. If so, document the name or name of the agency, phone number and relationship to person served.  |
| Data Field  | Legal Involvement and History Addendum  |
| <b>Legal Charges</b>  | Indicate the past or current legal charge(s) brought against the person, if any.  |
| <b>Designation</b>  | Check the applicable box to record whether the charge was in adult ,juvenile or civil court.  |
| <b>Status</b>   | Check the applicable box(es) that describe legal status of each charge.   |
| <b>Outcome</b>  | Check the applicable box(es) that describe the outcome.   |
| <b>Dates/Term (If Known)</b>  | Indicate the begin and end date of each charge's outcome listed.  |
| <b>Name and phone number of court (if applicable)</b>   | List the name and phone number of the court that processed the charge(s) against the person, if any.  |
| <b>Name and phone number of Probation/ Parole Officer (if applicable)</b>                           | List the first and last name of the probation or parole officer and his/her phone number. If the person is on probation or parole in another county, identify the county.   |
| <b>Domestic Relations Court Involvement (i.e., Custody, Protective Services, Restraining Order)</b> | Indicate all past and current domestic relations court involvement including dates for the person. Include any custody, protective services, legal guardian and/or restraining orders.  |
| <b>Current</b>  | Check applicable box and comment as needed.   |
| <b>Past</b>   | Check applicable box and comment as needed.   |
| <b>Juvenile Court Involvement (Related to Child Abuse, Neglect, or Dependency)</b>                  | Indicate if the person has been involved in the juvenile court system for reasons of abuse, neglect, or dependency.   |
| <b>Current</b>  | Check applicable box and comment as needed.   |
| <b>Past</b>   | Check applicable box and comment as needed.   |
| <b>Has a Child In Need of Services (CHINS) petition been filed?</b>                                 | Check applicable box and comment as needed.   |
| <b>Child Support Enforcement Orders</b>   | Record if the person is remanded to pay child support through his/her employer or other means. Record the person's reaction to the order.   |
| Data Field  | Education Addendum  |
| <b>Major/Degree(s)</b>  | Complete the name of the <i>Major(s)/Degree(s)</i> obtained and the year(s) completed.  |
| <b>Vocational Training</b>  | Check if none reported. Provide details if person is receiving vocational training, regardless of whether or not a certificate is received.   |
| <b>Vocational License(s)/Certification(s)</b>   | If person engaged in vocational training complete the name of the license(s) or certificate(s) obtained and year completed.   |
| <b>Educational Interests/ Skills</b>  | Check all boxes that apply and comment on specific issues/skills identified.  |
| <b>History of Learning Difficulties</b>   | Check all boxes that are pertinent to person's identified difficulties. This information may come from a variety of sources, including, but not limited to, the clinician conducting the intake. Include sources of   |

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|  | information under "other/comments". <b>Example: Learning Disability – Type: <u>dyslexia</u>.</b> Note if it is a past or a current issue for person served. Identify if any special communication needs are present as well as need for assisted verbal devices or communication boards.               |
| <b>Barriers to Learning</b>                                    | Check all boxes that apply, or indicate "other" and comment on any barriers that may/have interfered on person's ability to learn new information. Example: English is not Tom's native language, so he often has difficulty understanding the material presented in class.                            |
| <b>Data Field</b>  | <b>Employment Addendum</b>   |
| <b>Current Employment</b>                                      | Check all boxes that apply to record person's employment status.   |
| <b>Is person served satisfied with job</b>                     | Check the appropriate box.   |
| <b>Is person's served job in jeopardy</b>                      | Check the appropriate box. It is at the discretion of the agency as to whether or not to contact the person's supervisor if person's job is in jeopardy.   |
| <b>Not in Labor Force</b>                                      | If the person is not in the labor force, record the date last worked and check all boxes that apply to the person's situation.   |
| <b>Name of Most Recent Employer</b>                            | Identify the company name of the person's most recent employer, if any.  |
| <b>Reason(s) for Leaving Jobs in the Last 5 Years</b>          | Check all boxes that apply for all jobs in last five years, if any. Check Not Applicable (NA) if the person hasn't worked in the last 5 years.   |
| <b>Attendance</b>  | If the person has worked in the last 5 years, check the box that applies.  |
| <b>Performance</b>   | If the person has worked in the last 5 years, check the box that applies.  |
| <b>Data Field</b>  | <b>Military Service Addendum</b>   |
| <b>Military Experience</b>                                     | Check the appropriate box to indicate the branch(es) in which the person served in the past or is currently serving. Indicate dates of service, country served under, unit and major tasks of the unit, training and responsibilities, countries assigned to and combat experience.                    |
| <b>Honors/Medals/Citations</b>                                 | List all honors, medals and citations awarded.   |
| <b>Data Field</b>  | <b>Substance Use/Addictive Behavior History Addendum</b>   |
| <b>Have you ever used</b>                                      | Place a check next to each substance that the person reports having used. If <i>other</i> , identify the substance.  |
| <b>Age of First Use</b>  | Record age the person first used the addictive substance or engaged in the addictive activity.   |
| <b>Date of Last Use</b>  | Record the date the person last used the substance or engaged in the addictive activity.   |
| <b>Frequency</b>   | Check the appropriate box to indicate frequency of substance use.  |
| <b>Amount</b>  | Amount of substance used or activity engaged in. If amount has changed over time, record the range. <b>Example: 1- 5 bags of heroin per day.</b>   |
| <b>Method</b>  | Check the appropriate box to indicate the method of use. If other is checked, provide more detail.   |
| <b>Data Field</b>  | <b>SU/Addictive Behavior Service History</b>   |
| <b>None Reported</b>   | If None Reported, skip to the next question.   |
| <b>Substance Use Treatment</b>                                 | Check all boxes that apply.  |
| <b>Type of Service</b>   | Record the type of service received; be as specific as possible. <b>Examples: Inpatient, Detox, 30 Day Residential, Outpatient Group.</b>  |
| <b>Dates of Service</b>  | Record the approximate date range of service.  |
| <b>Reason</b>  | Record the reason that person received treatment. <b>Example: Cocaine addiction</b>  |
| <b>Name of Provider / Agency</b>                               | Record the name of the provider and/or agency.   |
| <b>Completed</b>   | Check if person completed the originally planned service. <b>Example: Check <u>No</u> if person left 30 day treatment program after 12 days.</b>   |
| <b>Toxicology Screen Completed</b>                             | Check all boxes that apply. If yes, record the results of the screen.  |
| <b>Other addictive behaviors</b>                               | Check appropriate box(es) if person reports current or history of other addictive behaviors.   |
| <b>Longest period of abstinence</b>                            | Record the longest period in which the person abstained from substance use/addictive behavior.   |
| <b>American Society of Addiction Medicine (ASAM) Degree of</b> | The ASAM matrix has been included in the assessment for those agencies that choose to utilize it as part of the assessment process. If ASAM level of care has been determined prior to assessment, this area may be optional. If completion of the scale is not required or the scale has already been |



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| <b>Severity at Admission</b> (SU persons served only)   | completed, check NA Refer to your agency's policies and procedures for completion of the ASAM Matrix.<br>The following websites provide additional information on the use of the ASAM matrix:<br><br><a href="http://www.asam.org/PatientPlacementCriteria.html">http://www.asam.org/PatientPlacementCriteria.html</a><br><a href="http://mass.gov/dph/bsas">http://mass.gov/dph/bsas</a><br><a href="http://www.neias.org/">http://www.neias.org/</a> |
| <b>If under age 18 dates of two attempts to quit prior to today</b>   | Person must have made two previous documented attempts to attain sobriety from opiates prior to today to qualify for admission to an OTP. Note dates (or approximate) of two previous attempts   |
| <b>Evidence of two or more proofs of narcotic dependence</b>  | Note details of symptoms that indicate that person is opiate dependent   |
| <b>Other Comments Regarding Substance Use</b>   | Record SU by other family members/significant others, SU-related legal problems, and stage of treatment for providers information. Include any additional comments on Substance Use/Addictive Behavior History.  |
| <b>Data Field</b>   | <b>Trauma History Addendum</b><br>(Describe in Comments Section Each Element Checked)  |
| <b>Multiple Fields: Physical Abuse; Domestic Violence/ Abuse; Elder Abuse; Financial Abuse; Community Violence*; Physical Neglect; Verbal/Emotional Abuse; Sexual Abuse/Molestation; Military Trauma; Other Trauma; Witness to Violence; Other</b> (What does the person identify as traumatic for them?) | For each traumatic event, describe specifics of trauma in the comments section to the right. Note if experience was single event or sustained over time.<br><br><b>*An example of Community Violence is gang violence</b>  |
| <b>Current Involvement by</b>   | Check the box(es) that apply. Add comments if necessary.   |
| <b>Additional Mandated Report Required?</b>   | If the person reports any activity that requires interviewer to report to an oversight agency, check the box(es) that apply. Add comments if necessary.  |
| <b>Data Field</b>   | <b>Staff Signatures – All Forms</b>  |
| <b>Provider – Print Name/Credential and title</b>   | <b>Legibly print</b> name and credential(s) of person completing the Comprehensive Assessment.   |
| <b>Date</b>   | Next to each signature record the date of the signature  |
| <b>Supervisor – Print Name/Credential (if needed)</b>   | If the diagnosis is rendered by a clinician other than the clinician printed above, then the clinician rendering the diagnosis must print his/her educational level and highest license level.   |
| <b>Date</b>   | Next to each signature record the date of the signature  |
| <b>Provider Signature</b>   | <b>Legible signature</b> of person completing the Comprehensive Assessment.  |
| <b>Date</b>   | Next to each signature record the date of the signature  |
| <b>Supervisor Signature (if needed) see also MDT requirements for day treatment and signatures.</b>   | If the diagnosis is rendered by a clinician other than the clinician signed above, then the clinician rendering the diagnosis must provide his/her signature and record his/her educational level and highest license level.   |
| <b>Person's Signature</b> (Optional, if appropriate)  | Signature of the person to be served by the agency indicating his/her understanding and acceptance of the treatment recommendation/assessed needs.   |
| <b>MD Signature (for SU/Addictive Behavior History Addendum only)</b>   | This is a requirement for Opiate Treatment Programs  |