ANNUAL ASSESSMENT UPDATE

This form is to be completed annually and is to accompany the Client/Coordination Plan. Responses should focus on changes in the respective areas since the last assessment and addressed in Client Plan, if appropriate.

Primary Language: _____ **Interpreter? Yes** ☐ **No** ☐ **Does the client request the family to act as interpreter? Yes** ☐ **No** ☐

1. What progress has the client made toward meeting objectives as identified in the previous Client Plan?

2. Describe the client's current symptoms/problems. (**To be completed by Licensed Mental Health Professional**)

3. Describe any Co-Occurring (substance abuse) issues influencing symptoms, impairments and treatment.

4. Describe any cultural factors influencing symptoms, impairments, and treatment.

5. Does the diagnosis remain the same? Yes ☐ No ☐ If No, a Change of Diagnosis form has been completed by Licensed Mental Health Professional and the diagnosis changed in the IS.

6. Current Status on Below Areas:

LIVING ARRANGEMENTS: Identify Current Status. Check all that apply.

☐	Homeless	☐	Long Term Residential Program	☐	Sober Living/Drug Rehabilitation Center
☐	Shelter	☐	Lives Alone - private home, rental unit	☐	Supportive housing, Section 8, etc.
☐	Board and Care	☐	Lives with Family/Relatives	☐	Satellite Housing (Semi - Independent Living)
☐	Crisis Residential Program	☐	Lives with other (unrelated)	☐	Skilled Nursing Facility
☐	Transitional Residential Program	☐	Lives with spouse/children	☐	At risk from removal from home
☐	Foster Care	☐	Group Home	☐	Other:

Do **mental health** symptoms affect Living Arrangements? If yes, or client wants change, explain:

SOCIAL SUPPORT: Identify Current Status. Check all that apply.

Is the family or significant others involved in treatment? Yes ☐ No ☐ If yes, family/SO provides support in the following areas:
Emotional ☐ Housing ☐ Tx Compliance/Relapse Prevention ☐ Recreation ☐ Education ☐ Transportation ☐ Financial ☐

☐	Socializes with others	☐	Is linked to self-help groups	☐	Requires outreach
☐	Develops and maintains friendships	☐	Is linked to other social or support groups	☐	Requires advocacy
☐	Has support of clergy	☐	Requires protection from abuse	☐	Other:
☐	Has a Power of Attorney; with whom?	☐	Has an Advance Directive	☐	Is Conserved; with whom?
☐	Has a Payee for Finances; with whom?	☐	Has a caretaker relationship; with whom?		

Do **mental health** symptoms affect Social Support? If yes, or client wants change, explain:

FINANCIAL/BENEFITS: Identify Current Status. Check all that apply.

☐	Medi-Cal	☐	GR/GA	☐	SB 90	☐	Indigent	☐	Family Preservation
☐	Medicare	☐	Unemployment benefits	☐	VA Benefits	☐	Family Support		
☐	Health Families	☐	HMO	☐	Private Insurance	☐	Participates in CalWORKs		
☐	SSI/SSDI	☐	SDI	☐	Employed	☐	Other		

Do **mental health** symptoms affect Financial Status/Money Management capability? If yes, or client wants change explain:

Name: _____ **MIS#:** _____

Agency: _____ **Prov#:** _____

Los Angeles County - Department of Mental Health

revision date: 01/23/2006

DAILY ACTIVITY / VOCATIONAL / EDUCATIONAL: Identify Current Status. Check all that apply.

☐	In School - identify level	☐	Supported Employment	☐	Full Time Work	☐	Is illiterate
☐	Part - Time work	☐	Sheltered Workshop	☐	Retired	☐	Has learning disability
☐	Occupational training	☐	Adult Day Health Care	☐	Isolates	☐	
☐	Attends a socialization program	☐	Senior Center Participation	☐	Has transportation needs	☐	

Do **mental health** symptoms affect Daily Activity/Vocational/Educational functioning? If yes, or client wants change, explain:

PHYSICAL HEALTH: Identify Current Status. Check all that apply.

☐	Describe medical problems: Last Physical:	☐	Needs medication counseling	☐	Needs Visual, Hearing Support:
☐	Describe dental problems: Last Dental Appt.	☐	Needs Medication Management	☐	Needs Ambulatory Support:
☐	Allergies:	☐	Requires Home Health	☐	Other:
☐	Describe nutritional problems:				
☐	Describe any physical/developmental handicaps:				

Do **mental health** symptoms affect Physical Health? If yes, explain: _____

Do **physical health** problems affect Mental Health? If yes, explain: _____

HOSPITALIZATION / CRISIS STABILIZATION / PMRT: Not Applicable ☐

Date(s) of hospitalizations last year:									
Identify reason(s):	☐	Med/Surg	☐	Psych	☐	Substance Abuse			
Identify Status:	☐	Voluntary	☐	Involuntary	☐	Conservatorship			
Was client admitted to an ER or Crisis Stabilization Unit, but not hospitalized within year?					☐	Yes	☐	No	☐ How many times
Was client seen by PMRT within year?					☐	Yes	☐	No	☐ How many times
Did any of the PMRT calls result in hospitalization?					☐	Yes	☐	No	☐ How many times

LEGAL: Not Applicable ☐

Did client have contact with police within year? ☐ Yes ☐ No If yes, identify type:							
Was the contact related to mental health issues? ☐ Yes ☐ No or substance abuse issues? ☐ Yes						☐	No
Was the client incarcerated within year?	☐	Yes	☐	No	If yes provide dates:		
Identify type of conviction	☐	Misdemeanor	☐	Felony	☐ Probation	☐	Parole
Was the conviction related to mental health issues? ☐ Yes ☐ No or substance abuse issues? ☐ Yes						☐	No
Did client become a ward of the court?					☐ Yes	☐	No
Was the client placed in Juvenile Hall/Camp within year?					☐ Yes	☐	No
Was treatment court ordered?			☐	Yes	☐ No	Name of Probation/Parole Officer	
Was this placement related to mental health issues? ☐ Yes ☐ No or a substance abuse issues? ☐ Yes						☐	No

Do **mental health** symptoms affect Legal Status? If yes, explain: _____

_____ _____

Service Provider Signature Date

How does client continue to meet Medical Necessity? (Diagnosis, Impairment, Intervention, EPSDT Criteria) **(To be completed by Licensed Mental Health Professional)**

_____

_____

_____

Annual Update reviewed and approved by:

_____ _____

Signature and Discipline **(Licensed Mental Health Professtional)** Date

Name: _____ **MIS#:** _____

Agency: _____ **Prov#:** _____

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