

Texas Resilience and Recovery: Child and Adolescent Uniform Assessment

Last Name: CMBHS Client Number:

Suffix: Local Case Number:

First Name:

Middle Name:

Component:

Location:

Assessment Type: Crisis Initial Update Discharge Initial Non-Admission

Referral Source: _____

If Discharge: Discharge Date: ____-____-____ Reason For Discharge: _____

Referred To: _____

At Risk of Placement ED (Special Education) Foster Care TCOOMI Consumer

Action Type: Add: ____ Correct/Modify: ____ Delete: ____

Section 1: Child and Adolescent Needs and Strengths (CANS)
(Completed by LMHA QMHP at Intake or Provider QMHP at Update)

A. CANS Assessment Date: - -

B. CANS 3-5 *or* 6-17 (Complete and attach appropriate form)

C. Calculated Level Of Care-Recommendation (LOC-R):

D. Provider Recommended Deviation (LOC-D): _____

E. Extended Review Period Requested (LOC-1 Only):

F. Performed By: _____ Credentials: _____

G. Notes:

Section 2: Community Data
(Completed by Provider QMHP Staff)

A. Community Data Assessment Date: - -

B. Number of Arrests in the last 30 days: _____

C. Has the child/youth attended school at any time in the past 3 months?
Yes No N/A

D. Current grade level or highest grade level completed: _____

E. Primary Residence Type (last 90 days):
1. Children's Residential Treatment Facility
2. Crisis Residential
3. Foster Care
4. Homeless
5. Institutional Setting
6. Jail or Correctional Facility
7. Living Independently
8. Other
9. Private Residence
10. Residential Care

F. Notes:

Section 3: Authorized Level of Care (LOC-A)
(Completed by LMHA Utilization Management Staff)

A. Actual Level of Care Authorized (LOC-A):
(Circle One)

LOC-0: Crisis Services
LOC-1: Medication Management
LOC-2: Targeted Services
LOC-3: Complex Services
LOC-4: Intensive Family Services
LOC-YC: Young Child
LOC-5: Transitional Services
LOC-6: Consumer Refuses Services
LOC-8: Waiting for All Authorized Services
LOC-9: Not Eligible for Services
LOC-YES: YES Waiver

B. Reasons for Deviation from LOC-R (Select One)*:
Clinical Need
Consumer Refused
Continuity of Care
Resource Limitations
Other
**See help file for instances when a note for reason for deviation is required*

C. Authorization Date: - -

D. Authorization End Date: - -

E. Subject to Medicaid Fair Hearing

F. Authorized By: _____ Credentials: _____

G. Notes: