Cornerstone Behavioral Healthcare

Annual Summary/Addendum to the IA

Client#:
Provider:

Client Name:	**DOB:**	**Date:**

Service Provided: ☐ Client Present ☐ Client not present

If client is present you will need to submit a progress note for the session.

☐ **Annual Update: If this is an Annual Summary, is it late?** ☐Yes ☐ No

If yes, please provide the reason for it being late:

☐ **Addendum: If this is an Addendum to the Initial Assessment, please answer the following question:**

Was the Co-Occurring Assessment done by Cornerstone Behavioral Healthcare? ☐Yes ☐No

If no, identify the facility and the date completed:

Is there a copy in the chart? ☐Yes ☐No, provider must complete a new Co-occurring Assessment

Identifying Information Update

1. Gender:
2. Living Arrangements: ☐Live alone ☐With others ☐Other:
3. Housing Adequate:
4. What financial resources does the client utilize?

Vocational Update ☐ **No change since Assessment/Annual**

Please explain any changes:

Leisure /Recreational Activity Update ☐ **No change since Assessment/Annual**

Please explain any changes:

Educational Update ☐ **No change since Assessment/Annual**

Please explain any changes:

Spiritual/Cultural/Ethnic History Update ☐ **No change since Assessment/Annual**

Please explain any changes:

Legal History Update ☐ **No change since Assessment/Annual**

Please explain any changes:

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Military Service Update ☐ **No change since Assessment/Annual**

Please explain any changes:

Mental Health Update ☐ **No change since Assessment/Annual**

Please explain any changes:

Physical Health Update ☐ **No change since Assessment/Annual**

Please explain any changes:

Substance Use & Other Addictions Update ☐ **No change since Assessment/Annual**

Please explain any changes (drug or other addiction/duration/frequency of use/amount used/how it is used/any applicable consequences):

1. Did the client undergo any treatment for substances? ☐Yes ☐No
   a. If yes, please explain:

2. Does client use tobacco? ☐Yes ☐No
   If yes, was a brief (3 minutes or less) tobacco cessation counseling intervention provided? ☐Yes ☐No

Current Provider Update ☐ **No change since Assessment/Annual**

Please explain any changes:

Medical Update ☐ **No change since Assessment/Annual**

1. Any changes since the Assessment/Annual in medications?
   ☐Yes (If yes, please add them on the "medication" tab in PIMSY) ☐No
   (Med Managers) Did you use the prescription monitoring system? ☐Yes ☐No

2. Has client become disabled since the Assessment/Annual? ☐Yes ☐No
   a. If yes, does the client receive disability? ☐Yes ☐No
   b. If yes, please explain:

3. Physical findings, labs, tests or consultant's reports? ☐Yes ☐No ☐N/A
4. Does client have a guardian or medical Power of Attorney (POA)? ☐Yes ☐No

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If yes, please explain:

5. Does client have a Psychiatric Advanced Care Plan? ☐Yes ☐No ☐N/A
   If no, and client is an AMHI Class Member was it offered? ☐Yes ☐No
   Please explain:

Trauma & Abuse Update **☐ No change since Assessment/Annual**

1. If any abuse or neglect, please explain:

Treatment Review Update & Summary (please list any changes and/or additions)

1. Client Strengths:

2. Client Challenges:

3. Any new barriers to treatment? ☐No change since last assessment ☐Yes
   If yes, please explain:

4. Summary (describe progress towards goals, objectives and/or change in level of care):

5. Is the client a youth in transition to adult services? ☐Yes ☐No ☐N/A

Crisis Assessment Update

1. Is the client at risk to harm self or others? ☐Yes (2-10) ☐No (1)
   If yes, please explain your rating:

2. Was Crisis Plan completed or updated? ☐Yes ☐No ☐N/A
3. Was Crisis Number given? ☐Yes ☐No ☐N/A

Diagnosis (include ICD code, description and date of diagnosis)

Provider Signature	Date
Printed Name & Credentials	
Supervisor Signature (if applicable)	Date