Cornerstone Behavioral Healthcare Acehelosu, a division of Cornerstone

Addendum To The Initial Co-Occurring Assessment

Client #
Provider

Client Name	**DOB**	**Date**
Start Time	**End Time**	

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

a. If no, identify the facility and the date completed:

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

2. Provider reviewed documentation appropriate for the service with client and/or guardian and obtained clients signatures as needed? ☐Yes ☐No

a. If no, please explain:

Identifying Information ☐ **No Change since Assessment**

(*Note providers & community agencies, housing, financial, and any other changes)*

1. Relational Status (please explain): ☐Divorced ☐Married ☐Other ☐Separate ☐Single ☐Widowed

2. Living Arrangements (please explain): ☐Live alone ☐With others ☐Other

3. Employment (If yes, please explain): ☐Yes ☐No

4. Types of Financial Aid: ☐MaineCare ☐Food Stamps ☐Housing ☐HEAP ☐N/A ☐Other (please explain: SSI/SSDI)

5. Any changes in sources of professional support for client or family since the Assessment? ☐Yes ☐No (if yes, please explain)

6. Any changes in sources of social support for client since the Assessment? ☐Yes ☐No (if yes, please explain)

7. Any changes in the following domains not previously identified in the Assessment? ☐Yes ☐No

a. If yes: ☐Emotional ☐Psychiatric ☐Psychological ☐Leisure/Recreational ☐Other

Legal History Update ☐ **No Change since Assessment**

If any changes since Assessment, please explain:

Military Service History Update ☐ **No Change since Assessment**

1. Does the client have any military service history since Assessment? ☐Yes ☐No **(*If yes, answer sub-questions*)**

a. What branch?

b. Is client on active duty? ☐Yes ☐No

c. If not, what type of discharge?

Updated Historical Data ☐ **No Change since Assessment**

If any changes since Assessment, please explain:

Updated Medical History

1. Any changes since Assessment: ☐Yes ☐No (If yes, please explain):

Client #
Provider

2. Does client have DNR form filled out? ☐Yes ☐No If yes, where is it located?
3. Has client become disabled since Assessment? ☐Yes ☐No **(*if yes, answer sub-question*)**
    a. Does client receive disability? ☐Yes ☐No (if yes, please explain)

Updated Substance History

1. Any changes since Assessment: ☐Yes ☐No **(*If yes, answer sub-questions*)**
    a. What type of substance use occurred?
    b. Did the client undergo any treatment for the use? ☐Yes ☐No (if any treatment, please explain):

Updated Crisis Assessment

1. Is the client at risk to harm self or others? ☐No (1 low) ☐Yes (2-10 high, please explain)

2. Crisis plan deemed necessary at this time? ☐Yes ☐No
3. Was Crisis Number given? ☐Yes ☐No

Updated Trauma & Abuse

1. Has any physical, sexual, emotional abuse or neglect occurred since the Assessment? ☐Yes ☐No
    a. If yes, please explain:

Client Strengths

Client Challenges

Barriers to Treatment

1. Any changes since Assessment: ☐Yes ☐No **(*If yes, please explain*)**

Summary (*In providers own words a summary of the addendum- include information regarding client's issues, any past services not previously disclosed, current recommendations, needs, and goals for treatment.*)

(*Case Management Only*)

1. LOCUS Date:
2. Composite Score:
3. Level of Care:
4. **Has there been a change in the Level of Care?** ☐Yes ☐No (If yes, please explain)

5. **Youth in Transition to Adult Services?** ☐Yes ☐No ☐N/A (If yes, please explain)

Client #
Provider

Diagnosis (*Include code & description*)	
(Direct-Enter Providers please enter the Diagnosis in the "diagnosis" tab in PIMSY)	
Primary:	
Secondary:	
Diagnosed By:	Dx Date:
Has the diagnosis changed since Assessment? ☐Yes ☐No **(*If yes, was Billing notified? ☐Yes ☐No*)**	
Provider Signature	**Date**
Printed Name & Credentials	
Supervisor Signature	**Date**