Comprehensive Assessment Addendums

Member Name _____

Member NSID or CIN _____

Care Management Agency _____

Completed By _____

Date Started _____

Date Completed _____

Addendum A: Physical and Mental Health Diagnosis and Treatment Table

Diagnosis and/or Symptom		
Severity	**Status**	***If Member declined Care Manager assistance, why?**
☐Mild ☐Moderate ☐Severe ☐Incapacitating	☐ Uncontrolled; requests Care Team assistance ☐ Uncontrolled; declines Care Team assistance* ☐ Controlled; Care Team assistance still needed ☐ Controlled or Resolved; No assistance needed*	
Past Treatment		

Is the member prescribed medications to assist in managing diagnosis/symptom?

☐ No → Why not?

☐ Yes → Review in Medications section

Is the member prescribed any form of treatment/services to address diagnosis/symptom?

☐ No → In the box below, provide narrative about why not and move to next section

☐ Yes → In the box below, provide a narrative about type, duration, frequency, last visit dates, etc.
Complete "**If Yes**" section

If Yes:

Who are the providers of the services? Include names and organizations

Are they adherent to and engaged in treatment or services related to their diagnosis or symptom?

☐ Yes → In the box below provide a narrative about satisfaction of services and what they do and don't like

☐ No → In the box below provide a narrative about why not and identify any barriers to care

☐ Does not agree to treatment/ services → In the box below, provide a narrative about why not