Comprehensive Assessment Addendums

Member Name _____

Member NSID or CIN _____

Care Management Agency _____

Completed By _____

Date Started _____

Date Completed _____

Addendum B: Substance Use Diagnosis and Treatment Table

Substance		
Route	Frequency	Amount Used
Start Date/ Time Period		
Currently Using?	☐ Yes per member ☐ No, per member and care team* ☐ No per member, Care Team identifies evidence of use*	
*If no, when and how does the member report they stopped using?		

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