



**HHUNY**  
HEALTH HOMES OF UPSTATE NEW YORK  
Empowering you. Expanding possibilities.

## Comprehensive Assessment Addendums

Member Name \_\_\_\_\_

Member NSID or CIN \_\_\_\_\_

Care Management Agency \_\_\_\_\_

Completed By \_\_\_\_\_

Date Started \_\_\_\_\_

Date Completed \_\_\_\_\_

# Table of Contents

Addendum A: Physical and Mental Health Diagnosis and Treatment Table..... 3

Addendum B: Substance Use Diagnosis and Treatment Table ..... 4

Addendum C: Hospitalizations ..... 5

## Addendum A: Physical and Mental Health Diagnosis and Treatment Table

Diagnosis and/or Symptom		
Severity	Status	*If Member declined Care Manager assistance, why?
<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Incapacitating	<input type="checkbox"/> Uncontrolled; requests Care Team assistance <input type="checkbox"/> Uncontrolled; declines Care Team assistance* <input type="checkbox"/> Controlled; Care Team assistance still needed <input type="checkbox"/> 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

## Addendum B: Substance Use Diagnosis and Treatment Table

Substance			
Route	Frequency	Amount Used	
Start Date/ Time Period			
Currently Using?		<input type="checkbox"/> Yes per member <input type="checkbox"/> No, per member and care team* <input type="checkbox"/> 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?	
<input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/> Incapacitating	<input type="checkbox"/> Uncontrolled; requests Care Team assistance <input type="checkbox"/> Uncontrolled; declines Care Team assistance* <input type="checkbox"/> Controlled; Care Team assistance still needed <input type="checkbox"/> 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

## Addendum C: Hospitalizations

Reason for Admission \_\_\_\_\_

Provide a narrative about outcome of hospitalization including any changes in treatment or diagnosis

Reason for Admission \_\_\_\_\_

Provide a narrative about outcome of hospitalization including any changes in treatment or diagnosis

Reason for Admission \_\_\_\_\_

Provide a narrative about outcome of hospitalization including any changes in treatment or diagnosis

Reason for Admission \_\_\_\_\_

Provide a narrative about outcome of hospitalization including any changes in treatment or diagnosis

Reason for Admission \_\_\_\_\_

Provide a narrative about outcome of hospitalization including any changes in treatment or diagnosis