

**Illinois Medicaid – Crisis Assessment Tool (IM-CAT)
Rating and Summary Sheet**

1. CLIENT INFORMATION				
First Name:	Last Name:	RIN:	Date of Birth:	Gender:
Insurance Coverage: <input type="checkbox"/> Medicaid - FFS <input type="checkbox"/> Medicaid – Managed Care <input type="checkbox"/> Private Insurance <input type="checkbox"/> None <input type="checkbox"/> Unknown			Insurance Company: <input type="checkbox"/> N/A	
Guardianship Status: <input type="checkbox"/> Own guardian <input type="checkbox"/> Youth in Care <input type="checkbox"/> Biological Parent <input type="checkbox"/> Other court appointed <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Other: _____		Interpreter Services: <input type="checkbox"/> None required <input type="checkbox"/> TDD/TYY <input type="checkbox"/> American Sign Language <input type="checkbox"/> Other: _____ <input type="checkbox"/> Spoken Language: _____		
Guardian Consent Received: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A				
2. SCREENING <input type="checkbox"/> Initial crisis screening <input type="checkbox"/> 24-hour non-emergency <input type="checkbox"/> Discharge <input type="checkbox"/> Other: _____				
Date of Call:	Time of Call: <input type="checkbox"/> am <input type="checkbox"/> pm	Crisis Screener (name):		Screener Credentials: <input type="checkbox"/> MHP <input type="checkbox"/> QMHP <input type="checkbox"/> LPHA
Date of Screening:	Begin Time of Screening: _____ <input type="checkbox"/> am <input type="checkbox"/> pm	End Time of Screening: _____ <input type="checkbox"/> am <input type="checkbox"/> pm		Diagnosis:
3. TRANSFERS <input type="checkbox"/> N/A				
<input type="checkbox"/> Hospital to Hospital	Sending Hospital: Receiving Hospital:	City/State: City/State:	Transfer Date:	
<input type="checkbox"/> SASS to SASS	Sending SASS: Receiving SASS:	City/State: City/State:	Transfer Date:	
4. DISPOSITION				
<input type="checkbox"/> Community stabilized (list community resources below) City/State: _____ Date: _____				
1. Name: _____	Resource Type: _____	Phone #: _____		
2. Name: _____	Resource Type: _____	Phone #: _____		
3. Name: _____	Resource Type: _____	Phone #: _____		
<input type="checkbox"/> Hospitalized at: _____ City/State: _____ Admission Date: _____				
5. MENTAL STATUS: Document clinical observations to support client’s current mental status as noted below.				
Appearance and Behavior:				
Threatening: <input type="checkbox"/> Yes <input type="checkbox"/> No	Mood: <input type="checkbox"/> WNL <input type="checkbox"/> Depressed <input type="checkbox"/> Manic <input type="checkbox"/> Anxious <input type="checkbox"/> Angry			
Suicidal: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Expansive <input type="checkbox"/> Labile			
Homicidal: <input type="checkbox"/> Yes <input type="checkbox"/> No	Affect: <input type="checkbox"/> WNL <input type="checkbox"/> Sad <input type="checkbox"/> Angry <input type="checkbox"/> Flat <input type="checkbox"/> Constricted			
Impulse Control: <input type="checkbox"/> Poor <input type="checkbox"/> Good	<input type="checkbox"/> Inappropriate			
Hallucinatory: <input type="checkbox"/> Yes <input type="checkbox"/> No	Insight: <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor			
Delusional: <input type="checkbox"/> Yes <input type="checkbox"/> No	Orientation: <input type="checkbox"/> WNL <input type="checkbox"/> Impaired			
Judgment: <input type="checkbox"/> WNL <input type="checkbox"/> Impaired	Cognition: <input type="checkbox"/> WNL <input type="checkbox"/> Loose Associations/Disorganized			
Memory: <input type="checkbox"/> WNL <input type="checkbox"/> Impaired	Please note: WNL = Within Normal Limits			

For all CAT domains, the following categories and action levels are used:

- | | | | |
|---|--|---|---|
| 0 | No evidence of any needs. | 2 | Action or intervention is required to ensure that the identified need is addressed. |
| 1 | Need that requires monitoring, watchful waiting, or preventive action. This may have been a risk behavior in the past. | 3 | Intensive and/or immediate action is required to address the need or risk behavior. |

Please note: Individual CAT items that are not applicable to the entire lifespan have specific age ranges for which the item must be completed indicated in front of the item name. If the item does not apply to the individual's age, rate the item "N/A."

6. ASSESSMENT

RISK BEHAVIORS	N/A	0	1	2	3		N/A	0	1	2	3
0-6: Self-Harm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Sexually Problematic Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1-6: Aggressive Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3-6: Flight Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Danger to Others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3+: Suicide Risk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Other Self-Harm (Recklessness)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3+: Decision-Making	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Non-Suicidal Self-Injur. Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3+: Intentional Misbehavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Delinquent/Criminal Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6-21: Runaway	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Community Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

BEHAVIORAL/EMOTIONAL NEEDS	N/A	0	1	2	3		N/A	0	1	2	3
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3-18: Oppositional	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3+: Anger Control/Frustration Tol.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adjustment to Trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3+: Impulsivity/Hyperactivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0-6: Atypical/Repetitive Behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Conduct/Antisocial Behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0-6: Emotional Control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Psychosis (Thought Disorder)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0-6: Failure to Thrive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	6+: Substance Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
0-21: Attachment Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FUNCTIONING NEEDS	N/A	0	1	2	3		N/A	0	1	2	3
Living Situation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1+: Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0-6: Feeding/Elimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Functioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0-21: School/Preschool/Daycare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental/Intellectual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	16+: Parental/Caregiving Role	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Compliance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	21+: Employment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PROTECTION	N/A	0	1	2	3		N/A	0	1	2	3
Safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Marital/Partner Violence in the Home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CAREGIVER RESOURCES & NEEDS	Client is their own guardian: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(if YES, skip this section)</i>					N/A	0	1	2	3
Supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Health/Behavioral Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Involvement with Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social Resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	0-21: Empathy with Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caregiver Residential Stability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

7. NOTES/COMMENTS/CLARIFICATIONS:

8. SIGNATURES		
Screener <i>(print name)</i>	Signature	Date
QMHP/LPHA Consult <i>(when applicable)</i>	Signature	Date of Consultation