DEPARTMENT OF HEALTH SERVICES
Division of Care and Treatment Services
F-22685 (11/2016)

STATE OF WISCONSIN
Completion of this form meets the requirements of Chapter 46.56, Section 14(c) of the Wis. Stats.

COLLABORATIVE SYSTEMS OF CARE (CSOC)
SUMMARY OF STRENGTHS AND NEEDS ASSESSMENT

Personally identifiable information is collected for monitoring the development of CSOC projects. All information gathered is confidential

Instructions: Complete the Summary of Strengths and Needs Assessment within 30 days of enrollment

Name – Child (Last, First, Middle Initial)	Telephone Number	Date of Birth	Social Security Number

Address – Home	County of Residence

PLEASE LIST OTHER PEOPLE WHO LIVE IN THE HOME OF THE CHILD

Relationship to Child	Name	Race*	Ethnicity*	Date of Birth	Gender	Marital Status*	Education Level*	Mailing Address (If different from above information)

***List of Codes:**

Race: **AI** = American Indian, **A** = Asian, B = Black or African American, H = Native Hawaiian or Other Pacific Islander, W = White
Ethnicity: H = Hispanic/Latino, NH = Not Hispanic/Latino
Marital Status: **Sg** = Single, **M** = Married, **Sp** = Separated, **D** = Divorced, **W** = Widowed, **LT** = Living Together
Educational Level: **01** = Elementary, **02** = Junior High, **03** = Some High School, **04** = High School Diploma/GED, **05** = Some College, **06** = College Degree
07 = Some Graduate School, **08** = Masters, **09** = Ph.D., **10** = Business/Trade School

Name – Service Coordinator (Case Manager)		Dates Updated

Date – Initial Assessment Started	Date – Assessment Completed	Funding Source
		☐ 01 = Medicaid ☐ 02 = SSI ☐ 03 = Private Insurance ☐ 04 = Katie Beckett ☐ 05 = Parents ☐ 06 = Other:

CRISIS / SAFETY

"A crisis occurs when adults don't know what to do." – Carl Shick

	Is this an Area of Strength?	Level of Need (1 = No need, 5 = Great need)
Have there been any crisis situations at home or in the community?	☐ Yes ☐ No	Crisis Response Plan for Home ☐1 ☐2 ☐3 ☐4 ☐5
	Name(s) – Person(s) in Need	

What was done in response to the situation(s)?	☐ Yes ☐ No Crisis Response Plan for Community ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need
Have there been any crisis situations at school?	☐ Yes ☐ No Crisis Response Plan for School ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need
What was done in response to the situation(s)?	☐ Yes ☐ No

Other Strengths	Other Needs

LIVING SITUATION

	Is this an Area of Strength?	Level of Need (1 = No need, 5 = Great need)
1. Describe your family's current living situation (Do all family members live at home?)	☐ Yes ☐ No	Living Arrangement ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need
2. Does your home provide enough space, privacy, and comfort? Describe:	☐ Yes ☐ No	Space, Privacy and Comfort ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need
3. Are there barriers to living in your current home long-term? Describe:	☐ Yes ☐ No	Stability of Living Arrangement ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need

4. Are there any safety concerns? Describe:	☐ Yes ☐ No Safety of Physical Environment ☐1 ☐2 ☐3 ☐4 ☐5
	Name(s) – Person(s) in Need

Other Strengths	Other Needs

RESTRICTIVENESS OF LIVING ENVIRONMENT

Only report living locations within past three months

Living Location Dates (List Start & End Dates)		Living Location (See choices at right)	Level of Restrictiveness (Use corresponding codes at right)
Start Date	End Date		

Living Environment and Level of Restrictiveness			
Jail	9.8	Individual Emergency Shelter Home	4.9
Correctional Center	9.0		
State Mental Hospital	9.0	Specialized Foster Care	4.6
County Detention Center	8.9	Regular Foster Care	3.8
Intensive Treatment Unit	8.4	Supervised Independent Living	3.6
AODA Inpatient Rehab	7.8	Home of Family Friend	2.6
Inpatient Hospital	7.5	Home of Adoptive Parent	2.6
Wilderness Camp 24-hour Year Round	7.2	Home of Relative	2.5
		School Dormitory	2.0
Residential Treatment Center	6.5	Home of Natural Parent (Child)	2.0
Group Emergency Shelter	6.0	Home of Natural Parent (18 yrs)	1.9
Residential Job Corps Center	5.7	Independent Living with Friend	1.4
Group Home	5.7	Independent Living on Own	0.5
Treatment Family Foster Home	5.1		

NOTE: Adopted from Hawkins, R.P.; Almelda, M.C.; Fabry, B.; & Reltz, A.C. (1991) Hospital & Community Psychiatry.

FAMILY

	Is this an Area of Strength?	Level of Need (1 = No need, 5 = Great need)
1. Describe relationships among family members	☐ Yes ☐ No	Family Relationships ☐1 ☐2 ☐3 ☐4 ☐5
		Name(s) – Person(s) in Need

2. Describe relationships with your extended family—are they a resource to your family?	☐ Yes ☐ No Extended Family Resource ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need
3. Who (other than family members) offers support to you and your family?	☐ Yes ☐ No Social Support Network ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need

Other Strengths	Other Needs

BASIC NEEDS / FINANCIAL

	Is this an Area of Strength?	Level of Need (1 = No need, 5 = Great need)
1. Are your family's housing, food, and clothing needs met?	☐ Yes ☐ No	Basic Needs ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need
2. Are your family's transportation needs met?	☐ Yes ☐ No	Transportation ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need
3. Please indicate your family's gross year income: _____ What are your family's sources of income? Is there enough income to meet the family's needs?	☐ Yes ☐ No	Financial Resources ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need
4. Please describe family members' money management skills	☐ Yes ☐ No	Money Management Skills ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need

5. Do family members have access to child care when needed—while adults are at work and when family members "just need a break"?	☐ Yes ☐ No Child Care and/or Respite ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need

Other Strengths	Other Needs

MENTAL HEALTH

1. Describe any significant psychological/psychiatric child and family history (past and current providers, medication, hospitalization, etc.)

	Is this an Area of Strength?	Level of Need (1 = No need, 5 = Great need)
2. Describe behavioral strengths and needs of your child and family members:	☐ Yes ☐ No	Behavioral Functioning ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need
3. Describe cognitive strengths and needs (learning ability, problem solving & thinking skills) of your child and family members:	☐ Yes ☐ No	Cognitive Functioning ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need
4. Describe emotional strengths and needs (reaction to stress, stability of mood) of your child and family members:	☐ Yes ☐ No	Emotional Functioning ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need
5. Do you have access to the mental health service providers your family needs or wants?	☐ Yes ☐ No	Access to Mental Health Providers ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need

Other Strengths	Other Needs

AODA (Alcohol and Other Drug Abuse)

	Is this an Area of Strength?	Level of Need (1 = No need, 5 = Great need)
1. Describe any current AODA abuse or addiction concerns regarding your child or other family members:	☐ Yes ☐ No	Current AODA Abuse or Addiction ☐1 ☐2 ☐3 ☐4 ☐5
	Name(s) – Person(s) in Need	
2. Describe past AODA abuse or addiction concerns regarding your child or other family members:	☐ Yes ☐ No	Past AODA Abuse or Addiction ☐1 ☐2 ☐3 ☐4 ☐5
	Name(s) – Person(s) in Need	
3. Do family members have access to needed AODA treatment and support?	☐ Yes ☐ No	Access to AODA Treatment & Support ☐1 ☐2 ☐3 ☐4 ☐5
	Name(s) – Person(s) in Need	
4. Describe the impact AODA issues have had on yourself and family members, both currently and in the past (include impact on social/community and family relationships, as well as on financial, legal, and employment situations):	☐ Yes ☐ No	Impact of AODA Issues ☐1 ☐2 ☐3 ☐4 ☐5
	Name(s) – Person(s) in Need	

Other Strengths	Other Needs

MENTAL HEALTH / AODA (Continued)

Please complete the following Mental Health DSM IV Diagnosis information and Child Adolescent Functioning Scale (CAFAS) information.

DSM IV DIAGNOSIS

Axis	Number	Name of Diagnosis
Axis I		
Axis II		
Axis III	☐ Yes ☐ No	
Axis IV Social Stressors	(1 = mild, 6 = severe) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6	
Axis V GAF at Intake		

Name – Author of Diagnosis | Date Diagnosed

On Medication at start date of services? ☐ Yes ☐ No If yes, specify medication(s) and daily dosage:

Notes/Comments

CHILD ADOLESCENT FUNCTIONING ASSESSMENT SCALE

Role Performance: School/Work	
Role Performance: Home	
Role Performance: Community	
Behavior Toward Others	
Moods/Emotions	
Self-Harmful Behavior	
Substance Use	
Thinking	
Youth Score	
Caregiver Resources: Material Needs	
Caregiver Resources: Family/Social Support	
Caregiver Resources Score:	

Date Administered

Name – Administered By

Notes/Comments

SOCIAL & RECREATIONAL

	Is this an Area of Strength?	Level of Need (1 = No need, 5 = Great need)
1. Social Interactive Skills: Do family members have friends? Why or why not? Do they get along well with others?	☐ Yes ☐ No	Social Interactive Skills ☐1 ☐2 ☐3 ☐4 ☐5
	Name(s) – Person(s) in Need	

2. Describe activities family members currently do together or would like to do together:	☐ Yes ☐ No Family Activities ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need
3. Describe activities your child or family members are involved in, or would like to be involved in, as individuals:	☐ Yes ☐ No Individual Social & Recreational Activities ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need
4. Describe social relationships—do family members spend time with people outside their immediate family?	☐ Yes ☐ No Social Relationships ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need

Other Strengths	Other Needs

CULTURAL

	Is this an Area of Strength?	Level of Need (1 = No need, 5 = Great need)
1. Describe ethnic or national traditions/holidays your family observes.	☐ Yes ☐ No	Affiliation with Ethnic Group ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need
2. How do family members participate in these traditions? Are there any barriers to participating in those traditions?	☐ Yes ☐ No	Access to Ethnic Traditions ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need

Other Strengths	Other Needs

SPIRITUAL

	Is this an Area of Strength?	Level of Need (1 = No need, 5 = Great need)
1. Describe your family's religious or spiritual practices, values, and support network.	☐ Yes ☐ No	Affiliation with Religious or Spiritual Group ☐1 ☐2 ☐3 ☐4 ☐5
		Name(s) – Person(s) in Need
2. Does your family have access to desire spiritual practices and support?	☐ Yes ☐ No	Access to Desire Practices & Support ☐1 ☐2 ☐3 ☐4 ☐5
		Name(s) – Person(s) in Need

Other Strengths	Other Needs

EDUCATIONAL

***Please attach a copy of the child's most recent school report card**

1. Describe your child's current educational status—include grade level, placement (LD-Learning Disabled, CD-Cognitively Disabled, ED-Emotionally Disturbed), and attendance.

	Is this an Area of Strength?	Level of Need (1 = No need, 5 = Great need)
2. Describe how your child is doing in his/her school work.	☐ Yes ☐ No	Academic Skills ☐1 ☐2 ☐3 ☐4 ☐5
		Name(s) – Person(s) in Need
3. Describe how your child is doing behaviorally in school.	☐ Yes ☐ No	Behavior in School ☐1 ☐2 ☐3 ☐4 ☐5
		Name(s) – Person(s) in Need

4 Do family members have age-appropriate independent living skills?	☐ Yes ☐ No Independent Living Skills ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need
5 If applicable, describe your child's work experience, pre-employment skills and interests.	☐ Yes ☐ No Pre-employment Skills ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need
6. Describe any educational or vocational strengths and needs of adult family members.	☐ Yes ☐ No Parent Education or Vocational Skills ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need

Other Strengths	Other Needs

LEGAL

	Is this an Area of Strength?	Level of Need (1 = No need, 5 = Great need)
1. Describe significant involvement with legal system and current status.	☐ Yes ☐ No	Need for Legal Services ☐1 ☐2 ☐3 ☐4 ☐5 Name(s) – Person(s) in Need

Other Strengths	Other Needs

CONTACT WITH POLICE AND/OR JUVENILE JUSTICE

(Only report offenses in the past six months)

Month/Year	Type of Violation	Taken into Custody?	Adjudicated?	Disposition (Use Codes Below)
		☐ Yes ☐ No	☐ Yes ☐ No	
		☐ Yes ☐ No	☐ Yes ☐ No	
		☐ Yes ☐ No	☐ Yes ☐ No	

Month/Year	Type of Violation	Taken into Custody?	Adjudicated?	Disposition (Use Codes Below)
		☐ Yes ☐ No	☐ Yes ☐ No	
		☐ Yes ☐ No	☐ Yes ☐ No	
		☐ Yes ☐ No	☐ Yes ☐ No	

DISPOSITION CODES:
01 Supervision, 02 Fine, 03 Restitution, 04 Secure Detention, 05 Non-Secure Detention, 06 Hospitalization, 07 CCI, 08 Group Home, 09 Foster Home, 10 Community Service, 11 Pending, 12 Informal Arrangements, 13 No Contact

MEDICAL

	Is this an Area of Strength?	Level of Need (1 = No need, 5 = Great need)
1. Describe the physical health of family members.	☐ Yes ☐ No	Physical Health ☐1 ☐2 ☐3 ☐4 ☐5
		Name(s) – Person(s) in Need
2. Describe the dental health of family members.	☐ Yes ☐ No	Dental Health ☐1 ☐2 ☐3 ☐4 ☐5
		Name(s) – Person(s) in Need
3. Do family members have access to needed health equipment or supplies?	☐ Yes ☐ No	Access to Special Equipment ☐1 ☐2 ☐3 ☐4 ☐5
		Name(s) – Person(s) in Need
4. Do family members have access to needed dental and health care providers?	☐ Yes ☐ No	Access to Dental & Health Care Providers ☐1 ☐2 ☐3 ☐4 ☐5
		Name(s) – Person(s) in Need

Other Strengths	Other Needs