Comprehensive Needs Assessment

In Chapter IV of the Mental Health Services, specific guidelines are provided for conducting a Comprehensive Needs Assessment (CNA). As part of our utilization management process, Acentra's Utilization Managers may request a copy of the CNA to obtain clinical information that may have been omitted from the Service Authorization Request (SRA). This information is crucial in ensuring that the individual receives the appropriate level of care and treatment they need.

Required Element	Element Details
1. Presenting Issue(s)/Reason for Referral: Chief Complaint	Indicate duration, frequency, and severity of behavioral health symptoms. Identify precipitating events/stressors, and relevant history.) If a child is at risk of out-of-home placement, state the specific reason and what the out-of-home placement may be
2. Behavioral Health History/Hospitalizations:	Give details of mental health history and any mental health-related hospitalizations and diagnoses. List family members and the dates and the types of mental health treatment that family members either are currently receiving or have received in the past.
3. Previous Interventions by providers and timeframes and response to treatment:	include the types of interventions that have been provided to the individual. Include the date of the mental health interventions and the name of the mental health provider.
4. Medical Profile	Describe significant past and present medical problems, illnesses, injuries, known allergies, current physical complaints, and medications. As needed, conduct an individualized fall risk assessment to indicate whether the individual has any physical conditions or other impairments that put them at risk for falling. All youth aged 10 years or younger should be assessed for fall risks based on age-specific norms.
5. Developmental History	Describe the individual as an infant and as a toddler: individual's typical effect and level of irritability; medical/physical complications/illnesses; interest in being held, fed, played with and the parent's ability to provide these; parent's feelings/thoughts about the individual as an infant and toddler. Was the individual significantly delayed in reaching any developmental milestones? If so, describe. Were there any significant complications at birth?
6. Educational/Vocational Status	School, grade, special education/IEP status, academic performance, behaviors, suspensions/expulsions, any changes in academic functioning related to stressors, tardiness/attendance, and peer relationships.
7. Current Living Situation, Family History, and Relationships	Describe the daily routine and structure, housing arrangements, financial resources, and benefits. Significant family history including family conflicts, relationships, and

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	interactions affecting the individual and family's functioning should be listed along with a list of all family or household members.
8. Legal Status: Indicate the individual's criminal justice status	Pending charges, court hearing date, probation status, past convictions, current probation violations, past incarcerations
9. Drug and Alcohol Profile:	Describe substance use by the individual and/or family members; specify the type of substance with frequency and duration of usage. Include any treatment or other recovery-related efforts.
10. Resources and Strengths	Document the individual's strengths, preferences, extracurricular, community and social activities, and extended family; activities that the individual engages in or are meaningful to the individual. These elements are key to developing an ISP that supports the individual's recovery and resiliency efforts and goals.
11. Mental Status Profile	Include findings and clinical tools used.
12. Diagnosis	The documentation of a diagnosis must include the DSM diagnostic code & description as documented by the LMHP that provided the diagnosis.
13. Professional Comprehensive Needs Assessment Summary and Clinical Formulation	Includes documentation of medically necessary services as defined by the service provider which: a. Identifies as much as possible, the causes of presenting treatment issues, and b. Identifies and discusses treatment options, outcomes, and potential barriers to progress, so that an individual-specific service plan can be developed.
14. Recommended Care and Treatment Goals	
15. Dated signatures of the LMHP, LMHP-R, LMHP-RP or LMHP-S	

Please review the Mental Health Services Provider Manual (Chapter IV) for additional information related to the Comprehensive Needs Assessment.