

CANS Transition to Adulthood Addendum

Data Field	Client Information
Person's Name (First, MI, Last)	Record first name, middle initial, and last name of the person served. Order of name is at agency discretion.
Record Number	Record agency's established identification number for the person.
Date of Admission	Record date the person served was admitted.
Organization/ Program Name	Record the organization and program for whom you are delivering the service.
DOB	Document date of birth of the person served.
Gender	Indicate person's gender by checking the appropriate box. If checking "Transgender" box, also complete box of current gender designation for insurance purposes.

Data Field	Transition to Adulthood
Independent Living Skills	If the child/adolescent is approaching adulthood, record relevant history and current status of child's independent living skills.
Transportation	Record relevant history and current status of child's transportation skills.
Personality Disorder	If applicable, record relevant history and current status of child's personality disorder
Parenting Roles	"If applicable, record significant history regarding child's parenting roles."
Medication Adherence	If applicable, record relevant history and current status of child's medication adherence.
Educational Attainment	Record relevant history and current status of child's educational attainment.
Financial Resources	Record relevant history and current status of child's financial resources.

Data Field	Signatures
Person's Signature (Optional, if clinically appropriate)	The person served should be given the option to sign the IAP. If the person served does not sign, list the reasons and an explanation on the IAP form, or document the reasons in a Progress Note and list the date here.
Date	Date of person's signature.
Parent/Guardian Signature	The signature of parent, guardian, or other legal representatives should be obtained when applicable. The provider should consult with his/her local provider agency's internal policies and procedures regarding the need for signatures of parents, guardians and other legal representatives.
Date	Date of Parent/Guardian Signature.
Clinician/Provider – Print Name/Credential	Legible clinician/provider name and credentials, according to agency policy, of the primary provider of services, coordinator of services, or the author of the plan.
Date	Date of this signature.
Supervisor – Print Name/Credential (if needed)	If applicable, legibly record signature and credentials of supervisor.

Date	Date of this signature.
Clinician/Provider Signature	Legible signature, according to agency policy, of the primary provider of services, coordinator of services, or the author of the plan.
Date	Date of this signature.
Supervisor's Signature (if needed)	Legible signature and credentials of supervisor. Example: Jerry Smith, LMHC
Date	Date of this signature.
Physician/MD/DO Signature (if required)	Legible physician's signature if required by agency policy. Please note certain payers do require physician's signature. This is a requirement for Opiate Treatment Programs