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| **Intensive Behavioral Health Screening Form** |

**DEMOGRAPHICS**

**Application Date: 1/31/2022**

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| **Youth’s Name:**  | **Birth date:**  | **Age:**  |
| **State of Birth:**  | **Adopted:** [ ] Yes [ ] No **If Yes, State of Adoption:** **Adopted through Child-Welfare Agency:**[ ]  Yes [ ]  No |
| **Gender Identity:** | **Ethnicity:** |
| **Height:**  | **Weight:**  |
| **School District:** **School:**  | **IEP or 504 plan:** [ ] Yes[ ] No |
| **DDA Application Pending:**  [ ] Yes [ ] No**DDA Enrolled:**  [ ] Yes [ ] No | **Tribal Affiliation/Enrollment:**  [ ] Yes [ ] No**If yes, which Tribe(s)?** |
| **Medicaid:** [ ] Yes [ ]  No**Managed Care Medicaid Plan:** **ProviderOne Client ID#:** | **Private Insurance:** [ ] Yes [ ]  No**Private Insurance Provider:**  |
| **Parent/Guardian Name:****Address:** | **Tel:** **Tel:** **EMAIL :** |
| **Does youth have a DCYF caseworker/social worker?** [ ]  Yes [ ]  No | **If yes, Name and Office Location of Caseworker/social worker:****Tel:** **EMAIL:**  |
|  ***FOR Managed Care Organization (MCO) or Behavioral Health-Administrative Services Organization (BH-ASO)*** ***OFFICIAL USE ONLY*** |
| **Referral Source:** Click or tap here to enter text. | **Tel:**  |
| **Date of local Review:**  | **Youth’s County of Origin:**  |
| **MCO or BH-ASO designee:**  | **Tel:**  |

**Psychiatric Services:**

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| **Diagnoses:** |
| **Name of Treating Psychiatrist or current prescriber:**  |
| **Current Behavioral Health Medications:**  |

**Substance Use Disorder (SUD) Treatment Episodes:**

|  |  |  |
| --- | --- | --- |
| **Agency** | **Admit/Intake Date** | **Discharge/Termination**  |
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Was a psychiatric evaluation completed within the past six months? [ ] Yes [ ] No

If yes, please include the psychiatric evaluation as supporting documentation (see yellow highlight below).

If you do not have a psychiatric evaluation completed within the last 6 months, do you have a psychiatric evaluation scheduled? [ ] Yes [ ] No

If yes, what date is it scheduled for and who is the provider? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please attach current Psychiatric evaluation completed within 6 months.**

Current Psychiatric Evaluation

This can be done either through an inpatient or outpatient treatment provider. This must be:

[ ]  Completed and signed by a psychiatrist or a psychiatric ARNP (PhD are *not* acceptable)

[ ]  Dated within the last 6 months

[ ]  Includes a DSM V Diagnostic classification

[ ]  Includes at a minimum a Mental Status Exam, and Complete Assessment of Treatment needs of the applicant.

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| **Youth Treatment History** |

**Psychiatric Hospitalizations:**

***(Please list in chronological order, listing most recent hospitalization first)***

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| **Facility** | **Admit Date(s)** | **Discharge Date(s)** |
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| **Use boxes below to enter information for ‘other’ or out of state hospitals** |
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**Department of Children, Youth and Families (DCYF) involvement within the last two years.**

**(Please use “other” section if you have duplicate services.)**

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| **Service** | **Agency****(if applicable)** | **Admit/Intake Date** | **Discharge/Termination Date** |
| Foster Care (including relative placement or foster home, not behavioral rehabilitation services)[ ]  Yes [ ]  No |  |  |  |
| Behavioral Rehabilitation Services (BRS): [ ]  Yes [ ]  No  |  |  |  |
| Family Preservation Services: [ ]  Yes [ ]  No |  |  |  |
|  Family Reconciliation Services:[ ]  Yes [ ]  No |  |  |  |
| Residential Care: [ ]  Yes [ ]  No |  |  |  |
| Other In-home Services:[ ]  Yes [ ]  No |  |  |  |
| Other: [ ]  Yes [ ]  No |  |  |  |
| Other: [ ]  Yes [ ]  No |  |  |  |
| Other: [ ]  Yes [ ]  No |  |  |  |

**Outpatient Mental Health Treatment Episodes (i.e. therapy, crisis services, psychiatric care, WISe)**

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| **Agency** | **Admit/Intake Date** | **Discharge Date**  |
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**Youth & Family Team Members** How frequently does the team meet?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **NAME** | **RELATIONSHIP/****AFFILIATION** | **PHONE NUMBER** | **Email Address** |
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**Narrative Section**

1. What are the challenges and/or behaviors the youth is experiencing that have led to the need for intensive psychiatric services and treatment?
2. Please describe:

**Youth’s** strengths/interests:

**Family’s** strengths/interests:

1. Describe what more intensive services have been tried in order to serve the youth in their community:

**Developmental, Family and Cultural History Narrative**

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| Please provide a *brief narrative* describing the youth’s **developmental, family and cultural history**. Information should describe:* Pregnancy, birth, developmental milestones
* Current living situation
* Name, occupation, marital status and location of natural and/or step-parents, adoptive parents or guardians
* Names and birth dates of siblings
* History of known psychiatric problems in the family
* Cultural background, including any specific practices of the youth and family

(or reference the *specific* document(s) which provides this information)Narrative:  |

 **Medical Status & Legal Status Narrative**

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| Please provide a *brief narrative* describing the youth’s current **legal status** including a description of current probationary or parole status, history of diversion, adjudication and incarceration, and a description of pending charges.(or reference the *specific* document(s) which provides this information)Narrative:  |

**Educational History Narrative**

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| Please provide a *brief narrative* describing the youth’s **educational history** including most recent school attended, whether currently attending, current performance in school and a brief outline of youth’s historical performance, and highest grade completed. (\*or reference the *specific* document(s) which provides this information)Narrative:  |

**Help Guide**

The following suggestions are made as you go through the pages of the screening form:

**Page One:**

1. **Medicaid/PIC#:** The number of the client is now known as the “Provider One” number or “Client Number” and is 8 digits followed by the letters WA.

2. **Private Insurance:**  We are asking for other private health insurance that may be in effect for the child.

3. **Telephone:** Please also add an EMAIL address if you have one. Staff are required to respect confidentiality if they send client information by email, and/or use an encrypted email system, but are able to discuss some arrangements by email. This speeds up communication.

4. Parents, please do not write in the shaded area.

**Page Five:**

1. Please include people currently (past 6 months) actively involved in helping the youth, If they will still be available to participate, please indicate with a check mark or \*.

2. Please include family members, (even if reluctant or currently estranged), community members and community providers.

3. If some of these members have been meeting regularly as a team to address the youth’s needs, please indicate how often the team meets.

**Page Seven:**

2. **Strengths:**  Listing these for the youth and family helps us use youth and family strengths to more quickly help all make progress.

3. **What more intensive services have been tried**….? We are interested in which services listed on previous pages have been helpful, what was not helpful, and why (brief).

**For MCO or BH-ASO use only**

**Recommendations:**

See Attached Recommendations Letter? [ ]  Yes [ ]  No (if no please answer below)

Refer to CLIP? [ ]  Yes [ ]  No

Refer to Least Restrictive Services? [ ]  Yes [ ]  No

Narrative of Recommendations: