# *Netsmart Children’s Comprehensive Assessment*

# Core Demographics

|  |  |
| --- | --- |
|  First Name: |  |
|  Last Name: |  |
|  DOB: |  |
|  Primary CIN: |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Line 1

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Line 2

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City State Zip code

|  |  |
| --- | --- |
|  Phone Type: |  |
|  |  |
|  Phone Number: |  |

# Children’s Demographic Information

All questions in this section are required, or conditionally required.

1. What is the member’s ethnicity?

|  |  |
| --- | --- |
| *Hispanic or Latino* | *Not Hispanic or Latino* |

2. What is the member’s race?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Alaskan Native/American Indian* | *Asian* | *Black/African American* | *Caucasian* | *Native Hawaiian/Pacific Islander* | *Other* | *Unknown/Not Provided* |

3. What is the member’s primary language?

4. Can you read/write in your primary language?

|  |  |
| --- | --- |
| *Yes* | *No* |

5. Are you experiencing any language and cultural barriers in trying to get the care you need?

|  |  |
| --- | --- |
| *Yes* | *No* |

6. Is there another language spoken in the home?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

6a. What is the member’s secondary language?

6b. Is a translator, interpretative services or native language speaker needed?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

6c. Who requires translation services?

7. What is the member’s religion?

7a. If Other, please specify:

8. How does the member describe their gender?

8a. Transgender identification:

|  |  |  |
| --- | --- | --- |
| *Male to Female* | *Female to Male* | *Gender non-conforming* |

9. What is the member’s sexual orientation?

10. Additional information regarding specific beliefs or customs that may impact the way your healthcare is delivered:

# **Social Determinants of** Health

All questions in this section are required.

\*All questions pulled directly from the AHC HRSN Screening Tool.

**Living Situation**

1. What is your living situation today?

|  |  |  |
| --- | --- | --- |
| *I do not have a steady place to live* | *I have a place to live today, but am worried about losing it in the future* | *I have a steady place to live* |

2. Think about the place you live. Do you have problems with any of the following?

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |  |  |
| --- | --- | --- | --- |
| *Pests, such as bugs, ants, or mice* | *Mold* | *Lead paint or pipes* | *Lack of heat* |
| *Oven or stove not working* | *Smoke detectors missing or not working* | *Water leaks* | *None of the above* |

 |  |

**Food**

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.

|  |  |  |
| --- | --- | --- |
| *Often True* | *Sometimes True* | *Never True* |

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

|  |  |  |
| --- | --- | --- |
| *Often True* | *Sometimes True* | *Never True* |

**Transportation**

5. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* |  |

**Utilities**

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Already shut off* |

**Safety**

**Because violence and abuse happens to a lot of people and affects their health we are asking the following questions.**

7. How often does anyone, including family and friends, physically hurt you?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Never* | *Rarely* | *Sometimes* | *Fairly Often* | *Frequently* |

 |  |

8. How often does anyone, including family and friends, insult or talk down to you?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Never* | *Rarely* | *Sometimes* | *Fairly Often* | *Frequently* |

 |  |

9. How often does anyone, including family and friends, threaten you with harm?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Never* | *Rarely* | *Sometimes* | *Fairly Often* | *Frequently* |

 |  |

10. How often does anyone, including family and friends, scream or curse at you?

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Never* | *Rarely* | *Sometimes* | *Fairly Often* | *Frequently* |

 |  |  |  |

# Benefits

All questions in this section are required, or conditionally required.

1. Does the member’s current household receive any of the following income sources? (Select all that apply)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *SSI/SSDI* | *Section 8* | *MRT Housing Subsidy* | *Child Support* | *Unemployment Insurance*  |  |
| *WIC* | *SNAP* | *Foster Care Subsidy* | *Employment* | *None* |

2. Does the member’s current household need any of the following benefits/entitlements? (Select all that apply)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *SSI/SSDI* | *Section 8* | *MRT Housing Subsidy* | *Child Support* | *Unemployment Insurance*  |  |
| *WIC* | *SNAP* | *Foster Care Subsidy* | *Employment* | *None* |

3. Does the member have financial supports/representative payee?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Member is under 18 years old* |

# **Medical History**

Starred (\*) questions are required.

\*1. Does the member have any medical problems/issues/diagnoses?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

1a. What are the member’s medical problems/issues/diagnoses?

2. Has the member been to the emergency room or admitted to the hospital in the past year for any of those issues?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Unknown* |

2b. How many times?

|  |  |
| --- | --- |
|  | *Choose answer:* |
| ER | 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 10+, Does not Recall, Refuse to answer |
| Hospital Admission | 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 10+, Does not Recall, Refuse to answer |

\*3. Does the member have a primary care doctor?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Unknown* |

3a. Who is the member’s primary care doctor? (Document the Provider in the Professional Network Section)

3b. When did the member last see their PCP?

4. Does the member see any medical specialists?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Unknown* |

4a. What medical specialists does the member see? (Document the Provider in the Professional Network Section)

5. Are any of the member’s medical issues bothering them especially/more than usual right now?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Unknown* |

\*6. Are the member’s immunizations up to date?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Unknown* |

\*7. When did the member last see their dentist?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Under 6 months* | *Over 6 months* | *Over a year* | *Do not recall* | *Never* |
|  |  |  |  |  |

\*8. What are the member’s current dental concerns and needs? Select all that apply.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Routine Care* | *Reports Pain* | *Gum Disease* | *Tooth Decay* | *Orthodontics* | *Phobia* | *None* |

 \*9. ***For Members who are self-consenting:***Decisions about health and medical care can be complicated. Is there someone in your life that you have identified or formally designated who would help you make decisions about your health care if you were unable to make those decisions for yourself?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Unknown* |

\*9a. Is this something you would like to learn more about?

|  |  |
| --- | --- |
| *Yes* | *No* |

# HIV/AIDS

Starred (\*) questions are required.

\*1. Has the member age 10 or older consented to share information about HIV/AIDS with the parent/guardian?

|  |  |  |  |
| --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Denies history* |

\*2. Does the member engage in risk behaviors for HIV? Select all that apply.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Injecting* | *Unprotected Sex* | *History of STIs* | *Refused to answer* | *Not age appropriate* | *Denies history* | *No* |

3. Has the member ever had an HIV test?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

3a. When was the date of the member’s last test?

4. Would the member like a referral for HIV testing?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

5. Has the member engaged in risky behaviors since their last test?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

6. Has the member ever been educated on HIV?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

7. Would the member like a referral for HIV education?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

\*8. Does the member have HIV+ or AIDS?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

8a. Was the member exposed to HIV Perinatally or after birth?

|  |  |
| --- | --- |
| *Perinatal* | *After birth* |

8b. Is the member been receiving medical care for HIV?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

9. What are the member’s barriers to accessing medical care?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| *Financial* | *Lack of Transportation* | *Need for Psychoeducation* | *Concerns about Side Effects* | *Communication Issues* | *Lack of Child Care* | *None* | *Other* |

9a. If Other, please specify:

10. When was the member’s last lab test that checked for CD4 count and Viral Load?

11. Does the member understand the meaning of Viral Load & CD4 count and how to read lab results?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

12. What is the member’s current CD4 count?

|  |  |  |
| --- | --- | --- |
| *>200* | *< or =200* | *Does not know* |

13. What is the member’s current viral load?

|  |  |  |
| --- | --- | --- |
| *Undetectable* | *Detectable* | *Unknown* |

# Complex Trauma

Starred (\*) questions are required.

\*1. Is the member eligible for HH services due to Complex Trauma?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

# Trauma

All questions in this section are required.

1. In your life, have you ever had any experience that was so frightening, horrible, or upsetting that you have had nightmares about it or thought about it when you did not want to?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Not sure* |

2. Have you tried hard not to think about it or went out of your way to avoid situations that reminded the member of it?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Not sure* |

3. Were constantly on guard, watchful, or easily startled?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Not sure* |

4. Have you felt numb or detached from others, activities, or your surroundings?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Not sure* |

# Mental Health Services

All starred (\*) questions are required.

\*1. Has the member (age 12 or older) consented to share information about Mental Health Services with the parent/guardian?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

\*2. Does the member have any behavioral/psychiatric problems/issues/diagnoses?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

*If Yes, please answer questions 3-8. If no, skip to question 9.*

3. What are the member’s mental health/behavioral/psychiatric problems/issues/diagnoses?

4. At what age didthe member’s mental health/behavioral/psychiatric problems/issues/diagnoses begin?

|  |  |  |  |
| --- | --- | --- | --- |
| *Adult* | *Adolescent* | *Child* | *Unknown* |

5. Has the member been to the emergency room or admitted to the hospital in the past year for any of those issues?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Unknown* |

5d. How many times?

|  |  |
| --- | --- |
|  | *Choose answer:* |
| ER | 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 10+, Does not Recall, Refuse to answer |
| Hospital Admission | 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 10+, Does not Recall, Refuse to answer |

6. Does the member have a psychiatrist (or psychiatric nurse practitioner)?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

6a. When did the member last see their psychiatrist (or psychiatric nurse practitioner)?

7. Does the member see a therapist?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

7a. When did the member last see their therapist?

8. Has the member been ordered by court to attend a program?

|  |  |  |  |
| --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Completed* |

\*9. **Patient Health Questionnaire: PHQ-9**

Over the last 2 weeks, how often have you been bothered by any of the following problems?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Not at all | Several days | More than half the days | Nearly every day |
| 1. Little interest or pleasure in doing things
 | 0 | 1 | 2 | 3 |
| 1. Feeling down, depressed, or hopeless
 | 0 | 1 | 2 | 3 |
| 1. Trouble falling or staying asleep, or sleeping too much
 | 0 | 1 | 2 | 3 |
| 1. Feeling tired or having little energy
 | 0 | 1 | 2 | 3 |
| 1. Poor appetite or overeating
 | 0 | 1 | 2 | 3 |
| 1. Feeling bad about yourself, or that you are a failure or have let yourself or your family down
 | 0 | 1 | 2 | 3 |
| 1. Trouble concentrating on things, such as reading the newspaper or watching television
 | 0 | 1 | 2 | 3 |
| 1. Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual
 | 0 | 1 | 2 | 3 |
| 1. Thoughts that you would be better off dead, or of hurting yourself
 | 0 | 1 | 2 | 3 |
|  **Total Score:** |
| 1. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?
 | Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult |

\*10. Is the PHQ-9 score positive?

|  |  |
| --- | --- |
| *Yes* | *No* |

#

# Medications

All questions are required, or conditionally required.

1. Is the member currently prescribed any medication?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |
|  |  |  |  |  |

1a. What medications is the member currently prescribed? Remember to attach the member’s medication list

1b. Does the member understand the reason for each medication?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

1c. Does the member ever have problems taking or remembering to take their medications?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Yes, for both medical and behavioral conditions* | *Yes, for medical conditions only* | *Yes, for behavioral health conditions only* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

1d. What difficulties does the member experience taking their medication as prescribed?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Financial* | *Lack of Transportation* | *Need for Psychoeducation* | *Concerns about Side Effects* | Communication Issues |
| *Provider Issue* | *Lack of Child Care* | *Child Declines* | *No difficulties noted* |  |

1e. Would the member like assistance in identifying supports to follow their prescription medications regimen?

|  |  |
| --- | --- |
| *Yes* | *No* |

2. What Pharmacy does the member go to?

3. Does the member have allergies?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |
|  |  |  |  |  |

3a. What are the member’s allergies?

#

# Substance Use Disorder

Starred (\*) questions are required.

\*1. Does the member (age 10 or older) consent to share information about Substance Use Disorder with their parent/guardian?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |
|  |  |  |  |  |

\*2. Has the member used Alcohol or Drugs within the past 12 months?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |
|  |  |  |  |  |

*If member answers yes to question 2, please conduct the CRAFFT Screening Interview below and answer 3a-7. If no, skip to question 8.*

3. **Drug Abuse Screening Test: CRAFFT Screening Interview**

## PART A

Screening using the CRAFFT begins by asking the member to “Please answer these next questions honestly”; reminding him/her of your confidentiality policy; and then asking 3 opening questions.

During the past 12 months, did you:

1. Drink any alcohol (more than a few sips)?

|  |  |  |
| --- | --- | --- |
|  | *Yes* | *No* |

2. Smoke any marijuana or hashish?

|  |  |  |
| --- | --- | --- |
|  | *Yes* | *No* |

3. Use anything else to get high? (“Anything else” includes illegal drugs, over the counter and prescription drugs, and things that you sniff or “huff”.)

|  |  |  |
| --- | --- | --- |
|  | *Yes* | *No* |

**Did the patient answer “yes” to any questions in Part A?**

If ***no***, ask CAR question only, then stop.

If ***yes***, ask all 6 CRAFFT questions.

## PART B

|  |  |  |  |
| --- | --- | --- | --- |
| **C** | Have you ever ridden in a **CAR** driven by someone (including yourself) who was “high”, or had been using alcohol or drugs? | *Yes* | *No* |
| **R** | Do you ever use drugs or alcohol to **RELAX**, feel better about yourself, or fit in? | *Yes* | *No* |
| **A** | Do you ever use alcohol or drugs while you are by yourself, or **ALONE**? | *Yes* | *No* |
| **F** | Do you ever **FORGET** things you did while using alcohol and drugs? | *Yes* | *No* |
| **F** | Do your family and **FRIENDS** ever tell you that you should cut down on your drinking or drug use? | *Yes* | *No* |
| **T** | Have you ever gotten into **TROUBLE** while you were using alcohol or drugs? | *Yes* | *No* |

***CRAFFT Scoring****: Each “yes” response in Part B scores 1 point. A total score of 2 or higher is a positive screen, indicating a need for additional assessment.*

3a. Is the CRAFFT scored 2 or higher?

4. Has the member ever gone to anyone for help for a drug or alcohol issue?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

4a. If yes, who?

5. Has the member ever been in a hospital for medical issues related to their drug or alcohol use?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |
|  |  |  |  |  |

5a. When was the last time the member was in a hospital for an issue related to their drug or alcohol use?

6. Is the member currently involved in an outpatient treatment program specifically related to drug or alcohol use?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Refused to answer* |
|  |  |  |

6a. If yes, what substance?

7. In the past has the member been treated for problems related to drug or alcohol abuse?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes – Detox – Inpatient* | *Yes – Inpatient treatment services (30 day rehab)* | *Yes – Methadone treatment – Methadone clinic* | *Yes – Outpatient services – Outpatient clinic* | *Yes – Outpatient services – Outpatient rehabilitation* |
| *Yes – residential services* | *Yes – Recovery center* | *Yes – Self-help group* | *No* |  |

\*8. Does the member smoke cigarettes, vape, or use other tobacco products?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

8a. Would the member like information about, or a referral for, smoking cessation?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

9. Does the member’s substance use/dependence affect their daily living?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

#

# Risk Behaviors and Factors

All questions in this section are required, or conditionally required.

1. Does the member (age 10 and older) consent to share information about Risk Behaviors and Factors with the parent/guardian?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

2. Does the member engage in self-harming behaviors?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

2a. If Yes, select all that apply:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Head banging* | *Cutting* | *Hair Pulling/Trichotillomania* | *Biting* | *Other*  |

2b. If other, please specify:

3. Does the member engage in fire setting behaviors?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

3a. Was the fire setting:

|  |  |  |
| --- | --- | --- |
| *Intentional* | *Accidental* | *Both* |

4. Does the member have any current at risk behavior related to suicide?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

4a. If yes, choose all that apply:

|  |  |  |  |
| --- | --- | --- | --- |
| *Ideation* | *Plan* | *Gestures/Threats* | *Attempts* |

4b. Please elaborate:

4c. Has the member been to the emergency room or admitted to the hospital in the past year for issues related to suicidal behavior?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

4d. How many times?

|  |  |
| --- | --- |
|  | *Choose answer:* |
| ER | 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 10+, Does not Recall, Refuse to answer |
| Hospital Admission | 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 10+, Does not Recall, Refuse to answer |

5. Has the member been to the emergency room or admitted to the hospital for issues related to aggressive or assaultive behavior?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

5a. How many times?

|  |  |
| --- | --- |
|  | *Choose answer:* |
| ER | 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 10+, Does not Recall, Refuse to answer |
| Hospital Admission | 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 10+, Does not Recall, Refuse to answer |

6. Has the member harmed or threatened to harm animals?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

7. Has the member engaged in any sexually aggressive behaviors towards others?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

7a. When?

|  |  |  |
| --- | --- | --- |
| *By history* | *Within the last 3 months* | *Both* |

7b. Has the member received treatment/support around these behaviors?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

8. Has the member exhibited sexually reactive behavior?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

9. Is the member engaging in unprotected sex?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

10. Has the member ever engaged in runaway behaviors?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

10a. What is the frequency of this behavior?

|  |  |  |  |
| --- | --- | --- | --- |
| *By history only* | *Every 3-6 months* | *1-2 times per month* | *Weekly* |

10b. When the member is AWOL, is her/his whereabouts known?

|  |  |  |  |
| --- | --- | --- | --- |
| *Always* | *Often* | *Sometimes* | *Never* |

10c. Additional details:

10d. What are the member’s reasons for running away?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Conflict with caregiver* | *Conflict with siblings* | *Safety Concerns* | *Quality of home environment* | *To spend time with peers* | *Other* |

10e. If Other, please specify:

10f. Have the member’s runaway behaviors ever resulted in police involvement?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

11. Does the member have any known eating disorder behaviors?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

11a. Which behaviors does the member engage in?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Hoarding* | *Binging* | *PICA* | *Withholding* | *Excessive Exercising* | *Other* |

11b. If Other, please specify:

11c. Has the member received treatment with regards to eating behaviors?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

12. Is the member currently involved, or have a history of involvement with the juvenile justice/legal system?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Yes* | *No* | *History of Involvement* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

12a. Does the member currently have a lawyer, probation officer, or supervision officer?

|  |  |
| --- | --- |
| *Yes* | *No* |

13. Are there any concerns regarding physical abuse, sexual abuse, or neglect on the part of the caregiver?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Currently in Placement* |

14. Has a call to the State Central Registry (SCR) ever been made?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

14a. When was the most recent SCR call?

|  |  |  |  |
| --- | --- | --- | --- |
| *In the last 6 months* | *6 months – 1 year ago* | *1-2 years ago* | *More than 2 years ago* |

14b. Has the member ever been removed from the home as a result of an SCR report?

|  |  |
| --- | --- |
| *Yes* | *No* |

14c. If yes, when was the member removed from the home?

|  |  |  |  |
| --- | --- | --- | --- |
| *In the last 6 months* | *6 months – 1 year ago* | *1-2 years ago* | *More than 2 years ago* |

15. Has the member engaged in bullying behaviors?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

15a. How recently have these behaviors occurred?

|  |  |  |  |
| --- | --- | --- | --- |
| *By history* | *Within last 3 months* | *Within the last month* | *Within the last week* |

15b. Is the member receiving support around these bullying behaviors?

|  |  |
| --- | --- |
| *Yes* | *No* |

16. Has the member ever been bullied?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

16a. How recently have these incidents occurred?

|  |  |  |  |
| --- | --- | --- | --- |
| *By history* | *Within last 3 months* | *Within the last month* | *Within the last week* |

16b. Is the member receiving support around these incidents?

|  |  |
| --- | --- |
| *Yes* | *No* |

# Activities of Daily Living

All questions in this section are required, or conditionally required.

1. In the past 7 days, did the member need help from others to perform every day activities such as eating, getting dressed, grooming, bathing, walking, or using the toilet? (Select all that apply)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| *Eating* | *Getting dressed* | *Grooming* | *Bathing* | *Walking* | *Using the toilet* | *Not age appropriate* | *Other* | *None* |

1a. If Other, please specify:

1b. Who helped the member with the tasks selected above?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Relative* | *Friend* | *Neighbor* | *Home Attendant* | *Foster Parent* | *No One* | *Other* |

1c. If Other, please specify:

2. In the past 7 days, did the member need help from others to take care of things such as laundry and housekeeping, banking, shopping, using the telephone, food preparation, transportation, or taking their own medications? (Select all that apply)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Laundry and Housekeeping* | *Banking* | *Shopping* | *Using the telephone* | *Food preparation* |
| *Transportation* | *Taking the member’s own medication* | *Not age appropriate* | *Other* | *None* |

2a. If Other, please specify:

2b. Who helped the member with the tasks selected above?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *Relative* | *Friend* | *Neighbor* | *Home Attendant* | *Foster Parent* | *No One* | *Other* |
|  |  |  |  |  |  |  |

2c. If Other, please specify:

3. Does the member require use of adaptive equipment/technology?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

3a. If yes, specify adaptive equipment/technology:

# Social Support

All questions are required, or conditionally required.

1.I have someone who understands my problems.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Never* | *Rarely* | *Sometimes* | *Usually* | *Always* |

2. I have someone who will listen to me hen I need to talk or if I am upset.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Never* | *Rarely* | *Sometimes* | *Usually* | *Always* |

3. I have someone to talk to when I have a bad day.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Never* | *Rarely* | *Sometimes* | *Usually* | *Always* |

4. I have someone I trust to talk with about my problems and feelings.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Never* | *Rarely* | *Sometimes* | *Usually* | *Always* |

5. I can get helpful advice when dealing with a problem.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Never* | *Rarely* | *Sometimes* | *Usually* | *Always* |

6.I get invited to go out and do things with other people.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Never* | *Rarely* | *Sometimes* | *Usually* | *Always* |

7. I can find a friend when I need one.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Never* | *Rarely* | *Sometimes* | *Usually* | *Always* |

8. I feel close to my friends.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Never* | *Rarely* | *Sometimes* | *Usually* | *Always* |

9. I feel like I’m part of a group of friends.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Never* | *Rarely* | *Sometimes* | *Usually* | *Always* |

# Developmental Milestones

Starred (\*) questions are required.

\*1. Are there any concerns about the member’s development?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

1a. Type of delay: (Select all that apply)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Cognitive* | *Communication* | *Adaptive* | *Social-Emotional* | *Physical Development* |

\*2. Is there documentation of the developmental delay?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Does not know* |

*If yes, please answer 2a-5a. If no, skip to question 6.*

2a. Date of last assessment:

3. How many days per week does the member receive therapy/services?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *0* | *1* | *2* | *3* | *4* | *5* | *6* |

4. Are there any risks associated with developmental conditions? (Select all that apply)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| *Social vulnerability* | *Physical concerns* | *Financial* | *Wandering* | *Academic* | *Other* |

5. Are referrals or supports needed?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

5a. Enter additional referrals or support required:

\*6. Is this member receiving Early Intervention services?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

6a. What provider?

6b. How many days per week does the member receive EI services?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| *0* | *1* | *2* | *3* | *4* | *5* | *6* |

6c. Which developmental milestones aren’t within normal limits?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Grasp items* | *Lift head* | *Crawling* | *Talking 1-2 word sentences* | *Talking 3-4 word sentences* |
| *Sit with support* | *Sit without support* | *Walking* | *Potty training* | *Other* |

6d. If Other, please specify:

7. Does the member have a history of receiving EI services?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

\*8. Additional information pertaining to member’s development:

#

# School/Academic Function

All questions in this section are required, or conditionally required.

1. Is the member attending school?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

1a. Enter school name:

1b. School Grade:

2. What is the member’s school setting?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *School* | *Alternative Program* | *GED* | *College Prep* | *College* |

3. What is the member’s attendance frequency?

|  |  |  |
| --- | --- | --- |
| *Typically present daily* | *1-2 absences per month* | *1 absence per week or more* |
| *Cuts classes* | *Appointment interfering with school* | *Not attending* |

4. What educational services is the member receiving?

|  |  |  |  |
| --- | --- | --- | --- |
| *General Education* | *Special Education* | *Has an IEP* | *Referral for CSE Evaluation Needed* |

*5.* What are the current services and accommodations in the school system?

*5a.* What are the frequency of services?

6. What is the member’s typical behavior at school?

|  |  |  |  |
| --- | --- | --- | --- |
| *No Issues Reported* | *Positively Adjusted to School Environment* | *Behavior is Impacting on Learning* | *Behavior is At Risk of Suspension* |

7. Describe the Home-School partnership for the member.

|  |  |  |  |
| --- | --- | --- | --- |
| *Present* | *Collaborate* | *Adversarial* | *Non-Existent* |

8. Are the member’s needs being addressed by their school?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

 9. *If the member is 17 or older who are not currently enrolled*: Is the member interested in completing any more education?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

10. Are medical accommodations needed?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

11. Is advocacy needed?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

# Employment

All starred (\*) questions are required.

\*1. Is the member 14 years old or older?

|  |  |
| --- | --- |
| *Yes* | *No* |

2. Is the member currently employed?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

2a. If no, is the member interested in getting a job?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

2b. Does the member want or need workforce development training and education?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *Yes* | *No* | *Refuse to answer* | *Not age appropriate* | *Denies history* |

3. Does the member have access to vocational rehabilitation and employment programs?

|  |  |  |
| --- | --- | --- |
| *Yes* | *No* | *Not sure* |

4. Are there any barriers to gaining or maintaining employment?

# Priorities

What are the most important things to work on right now and how can the care manager help accomplish this?