Intensive Behavioral Health Screening Form

DEMOGRAPHICS

Application Date:

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:	**Tel:**	
Date of local Review:	**Youth's County of Origin:**	
MCO or BH-ASO designee:	**Tel:**	

Psychiatric Services:

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

Substance Use Disorder (SUD) Treatment Episodes:

Agency	Admit/Intake Date	Discharge/Termination

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.

Youth Treatment History

Psychiatric Hospitalizations:

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

Facility	Admit Date(s)	Discharge Date(s)
Use boxes below to enter information for 'other' or out of state hospitals		

Department of Children, Youth and Families (DCYF) involvement within the last two years. (Please use "other" section if you have duplicate services.)

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)

Agency	Admit/Intake Date	Discharge Date

Youth & Family Team Members How frequently does the team meet?_____

NAME	RELATIONSHIP/ AFFILIATION	PHONE NUMBER	Email Address

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:

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

Developmental, Family and Cultural History Narrative

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

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

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: