Intensive Behavioral Health Screening Form

DEMOGRAPHICS

Application Date: 5/5/2023

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:**	

ADMINISTRATION

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? _____

SUP ADMINISTRATION

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		

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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.)

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

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

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:

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

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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:

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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:

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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:

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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).

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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:

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