

## Children and Youth (C/Y) Enhanced Care Management Comprehensive Assessment

This assessment is a tool for you, as Lead Care Manager, to assess a C/Y member's health needs and help the C/Y member participate in the Enhanced Care Management (ECM) benefit. From the initial and over the next 1-3 visits, you and the C/Y member will complete this assessment together, and from there develop goals and next steps that support the C/Y member's overall health and wellness.

### **Section 1. Indicate the C/Y member's Population of Focus and other County programs they are involved in**

The purpose of this section is to identify other programs the C/Y member is involved in; and support you to coordinate the C/Y member's care and health-related social needs.

<b>Population of Focus for the C/Y member:</b>	
<input type="checkbox"/> Experiencing homelessness	<input type="checkbox"/> At-risk for avoidable hospital/emergency department (ED) utilization
<input type="checkbox"/> Serious mental illness (SMI)/substance use disorder (SUD)	<input type="checkbox"/> Transitioning from youth correctional facility
<input type="checkbox"/> California Children's Services (CCS)/CCS Whole Child Model (WCM)	<input type="checkbox"/> Child welfare
<input type="checkbox"/> Intellectual/developmental disorder (DD)	<input type="checkbox"/> Birth equity <i>(As identified on the referral/authorization form)</i>
<b>Programs the C/Y member is involved in:</b>	
<input type="checkbox"/> Specialty mental health services (SMHS)	<input type="checkbox"/> Drug Medi-Cal (DMC)
<input type="checkbox"/> Drug Medi-Cal Organized Delivery System (DMC-ODS)	<input type="checkbox"/> Juvenile Justice
<input type="checkbox"/> CCS	<input type="checkbox"/> CCS WCM
<input type="checkbox"/> Child welfare	
<input type="checkbox"/> Regional center services	<input type="checkbox"/> Local program serving pregnant/postpartum individuals (e.g., Comprehensive Perinatal Services Program [CPSP], California Home Visiting Program [HVP], etc.), list: _____
<input type="checkbox"/> Other(s), list: _____	<input type="checkbox"/> N/A
<b>Date of consent for opt-in to ECM services:</b> _____	
<input type="checkbox"/> Verbal	<input type="checkbox"/> Written
<input type="checkbox"/> C/Y member	<input type="checkbox"/> Parent/guardian/caregiver
<input type="checkbox"/> Department of Children and Family Services (DCFS)	
<input type="checkbox"/> Court	<input type="checkbox"/> Foster parent(s)
<b>Is anyone else in the family enrolled in ECM?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, list family member name(s), relationship(s) to the C/Y member, and ECM provider(s):	

### **Indicate if you used any of the following recently completed assessments or tools to complete/inform this assessment.**

The Lead Care Manager should incorporate findings from all available assessments. Assessments do not replace this comprehensive assessment but should inform development of the care plan.

<input type="checkbox"/> ACEs or PEARLS	<input type="checkbox"/> Yes. Date completed: _____	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<i>If no ACEs or PEARLS screening completed: refer to PCP/SW for screening.</i>			
<input type="checkbox"/> CANS Assessment <sup>1</sup>	<input type="checkbox"/> Yes. Date completed: _____	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<input type="checkbox"/> PSC-35 <sup>2</sup>	<input type="checkbox"/> Yes. Date completed: _____	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<input type="checkbox"/> Needs Evaluation Tool <sup>3</sup>	<input type="checkbox"/> Yes. Date completed: _____	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<input type="checkbox"/> Youth Screening Tool <sup>4</sup>	<input type="checkbox"/> Yes. Date completed: _____	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<input type="checkbox"/> (DPH Foster Care) Child Health Evaluation	<input type="checkbox"/> Yes. Date completed: _____	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<input type="checkbox"/> Protective Factors Survey <sup>5</sup>	<input type="checkbox"/> Yes. Date completed: _____	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<input type="checkbox"/> (DCFS) Multidisciplinary Assessment Team <sup>6</sup>	<input type="checkbox"/> Yes. Date completed: _____	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<input type="checkbox"/> (CCS) Patient Care Assessment	<input type="checkbox"/> Yes. Date completed: _____	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<input type="checkbox"/> (DDS) Regional Center Assessment	<input type="checkbox"/> Yes. Date completed: _____	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<input type="checkbox"/> (Pregnant/Postpartum) CPSP Assessment	<input type="checkbox"/> Yes. Date completed: _____	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<input type="checkbox"/> (Justice Involved) Re-entry Transition Plan	<input type="checkbox"/> Yes. Date completed: _____	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<input type="checkbox"/> Other(s) (list with date completed):			

<sup>1</sup> The Child and Adolescent Needs and Strengths Assessment is used by DCFS/Child Welfare and by SMHS/DMH

<sup>2</sup> The Pediatric Symptom Checklist is used by SMHS/DMH

<sup>3</sup> The Needs Evaluation Tool is used by DMH

<sup>4</sup> The Youth Screening Tool is used for Medi-Cal Mental Health Services, DHCS

<sup>5</sup> The PFS is used by the Prevention and Aftercare Network, DCFS

<sup>6</sup> The Multidisciplinary Assessment Team includes their level of care tool and the Resource Family Reporting Tool, used by DMH for a child newly entering the foster care system

**Section 2. Demographics and C/Y Member's Needs / Preferences**

C/Y Member and Family Demographics	
Primary point of contact for ECM services: <input type="checkbox"/> C/Y member <input type="checkbox"/> Parent/guardian/caregiver <input type="checkbox"/> Other (list): _____	Person(s) you are speaking with to complete this assessment (select all that apply): <input type="checkbox"/> C/Y member <input type="checkbox"/> Parent/guardian/caregiver <input type="checkbox"/> Other (list): _____
Today's date:	C/Y member's name:
Date of birth:	Medi-Cal ID:
C/Y member's preferred name and/or pronouns:	C/Y member's gender identification:
Preferred written/spoken language ( <i>What language are you most comfortable speaking and reading?</i> ): C/Y member: _____ Parent/guardian/caregiver: _____	Interpreter needed: <input type="checkbox"/> Yes <input type="checkbox"/> No Language: _____
Do you have any cultural, religious and/or spiritual beliefs that are important to your family's health and wellness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer If yes, describe:	
Relationship status of C/Y member: <input type="checkbox"/> N/A <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic partnership <input type="checkbox"/> Widowed <input type="checkbox"/> Other: _____ <input type="checkbox"/> Declined to answer	Relationship status of parent/guardian/caregiver: <input type="checkbox"/> N/A <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Domestic partnership <input type="checkbox"/> Widowed <input type="checkbox"/> Other: _____ <input type="checkbox"/> Declined to answer
Parent/guardian/caregiver name: Contact information: <input type="checkbox"/> Biological <input type="checkbox"/> Adoptive <input type="checkbox"/> Foster <input type="checkbox"/> Guardian/conservator <input type="checkbox"/> Court appointed guardian <input type="checkbox"/> Joint legal custody <input type="checkbox"/> Sole legal custody <input type="checkbox"/> Joint physical custody <input type="checkbox"/> Sole physical custody <input type="checkbox"/> Unaccompanied youth/minor <input type="checkbox"/> Refugee <input type="checkbox"/> Asylum seeker <input type="checkbox"/> N/A emancipated minor	
C/Y member's nationality/tribe/ethnicity: Select all that apply. <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander/Native Hawaiian <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Other: _____	
C/Y member's current level of education: <input type="checkbox"/> Elementary school <input type="checkbox"/> Junior high school <input type="checkbox"/> High school <input type="checkbox"/> Some college <input type="checkbox"/> Completed college <input type="checkbox"/> Technical school or training <input type="checkbox"/> Other (list): _____ <input type="checkbox"/> N/A	
Parent/guardian/caregiver highest level of education: <input type="checkbox"/> Elementary school <input type="checkbox"/> Junior high school <input type="checkbox"/> High school <input type="checkbox"/> Some college <input type="checkbox"/> Completed college <input type="checkbox"/> Technical school or training <input type="checkbox"/> Other (list): _____ <input type="checkbox"/> N/A	
Does the C/Y member have a caregiver assisting them? <input type="checkbox"/> Yes <input type="checkbox"/> No If provided, list name and contact information: Does the C/Y member have an In-Home Supportive Services (IHSS) worker? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the IHSS worker's name(s) and contact information: _____	
Does the C/Y member need a caregiver? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain: Does the C/Y member's caregiver need additional help or training to provide care? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Declined to answer If yes, please explain:	
Additional family members or other caregivers assisting the C/Y member (for example, daycare, nanny, family member, friends, siblings)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Declined to answer List:	

Does the C/Y member have a job? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Declined to answer		
If yes, list:		
If yes, <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time <input type="checkbox"/> Day laborer		
<b>C/Y Member Needs and Preferences</b>		
What is the C/Y member's most important issue or need right now, as related to health, wellness, living situation, or something else?		
<b>Contact Information</b>		
Preferred place to receive mail:	Home phone(s):	Cell phone(s):
Preferred method of contact (select all that apply): <input type="checkbox"/> In-person <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Text	Email address(es):	
<b>Emergency Contact</b>		
Name:		
Relationship:		
Contact information:		

**Section 3. Health Literacy**

The following questions will be used to assess how the C/Y member (or their parent/guardian/caregiver, if applicable) believes they are managing their health conditions.

Does the C/Y member (or their parent/guardian/caregiver, if applicable) need education or resources to help them understand the C/Y member's care and treatment needs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Declined to answer
Does the C/Y member (or their parent/guardian/caregiver, if applicable) express needing help in answering questions during a doctor's visit? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Declined to answer
Does the C/Y member (or their parent/guardian/caregiver, if applicable) express needing help in filling out health forms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Declined to answer

**Section 4. Physical Health**

The following questions will be used to assess the C/Y member's current physical health needs and conditions.

Has the C/Y member (or their parent/guardian/caregiver, if applicable) been told by a doctor or medical provider that they have any medical conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please check all that apply: <input type="checkbox"/> Asthma/chronic lung disease <input type="checkbox"/> Cancer <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Cleft lip/palate <input type="checkbox"/> Congenital heart defect <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Pre-diabetes <input type="checkbox"/> Diabetes Type 1 <input type="checkbox"/> Diabetes Type 2 <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Hypertension ( <i>high blood pressure</i> ) <input type="checkbox"/> Kidney disease <input type="checkbox"/> Muscular dystrophy <input type="checkbox"/> Physical disability/para/quadruplegic/amputation <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Spina bifida <input type="checkbox"/> Organ Transplant (list): _____ <input type="checkbox"/> Genetic condition(s) (list): _____ <input type="checkbox"/> Other conditions not listed above (list): _____
Does the C/Y member have trouble with vision? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____
Glasses/contacts: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Need
TTY (visual support) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Need
Other:
If the C/Y member has diabetes, has a Diabetic Eye Exam been done in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Does the C/Y member have trouble with hearing? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe: Hearing device(s): <input type="checkbox"/> Yes (list): _____ <input type="checkbox"/> No <input type="checkbox"/> Need
In general, would the C/Y member (or their parent/guardian/caregiver, if applicable) say their physical health is: <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Declined to answer Please give more information about why the C/Y member (or parent/guardian/caregiver) chose this rating:

Has the C/Y member been to the hospital, emergency room, or a skilled nursing facility in the past 12 months?

Yes  No  N/A  Declined to answer

If yes, how many times and what for? (list all):

Does the C/Y member have a regular primary health care provider or medical home?  Yes  No

If yes, please fill out the following information:

Name of primary care provider:

Contact number:

Office address:

Purpose of last visit:

Date of last visit (if known, or an approximate date):

Does the C/Y member have a regular dentist or dental home?  Yes  No

If yes, please fill out the following information:

Name of dentist:

Contact number:

Office address:

Purpose of last visit:

Date of last visit (if known, or an approximate date):

Does the C/Y member currently have any dental health issues or needs?  Yes  No  N/A  Declined to answer

Does the C/Y member receive care from any additional providers/specialists (mark all that apply):

- Cardiology  Developmental-behavioral pediatrics  Endocrinology  Genetics  Hematology  
 Immunology/infectious disease  Neurology  Oncology  Orthopedics  Pulmonology  Respite  
 Physical therapy  Occupational therapy  Speech therapy  Feeding therapy  
 Other (list): \_\_\_\_\_

If applicable, document name/contact information for each additional provider/specialist:

### Medications

Please tell me what medications the C/Y member is currently taking:

Medication name	How often (frequency)	How administered (route)	Dosage

Please attach list for additional medications.

Has the C/Y member (or their parent/guardian/caregiver, if applicable) had difficulty with filling the member's medications in the last year?  Yes  No

If yes, explain why:

Were there any days in the past week the C/Y member did not take medications as prescribed?  Yes  No

If yes, please describe what gets in the way:

### Pain and Symptom Management

Does the C/Y member currently experience pain?  Yes  No  Declined to answer

**If yes, answer the questions below.**

During the past week, how much did the C/Y member's pain, or medical condition, interfere with normal activities (including going to school, playing with friends, or work outside the home and/or housework)?

Not at all  A little bit  Moderately  Quite a bit  Extremely  Declined to answer

Does the C/Y member have supports, services, or routines to help them manage their pain and/or medical condition(s) (e.g., palliative care provider, meditation, therapies [list], medications, family/friend support)? Write in the space below if applicable.

Yes  No  Declined to answer

If yes, please write below which supports, services, or routines the C/Y member currently has.

### **Section 5. Pregnancy/Postpartum**

*Only complete if C/Y member is of child-bearing age. If not, skip to Section 6.*

Questions not reviewed for the C/Y member (child has not reached puberty/first menstrual period)

Questions not reviewed for the C/Y member (other reason – indicate reason: \_\_\_\_\_)

Is the C/Y member currently pregnant?  Yes  No  N/A  Declined to answer

*If no or N/A, skip to postpartum questions.*

If yes, how many weeks pregnant?

Has the pregnancy been disclosed to the parent/guardian/caregiver?  Yes  No  N/A

Has the C/Y member given birth in the last 12 months?  Yes  No  N/A  Declined to answer

**If yes to currently pregnant, please complete below**

Expected date of delivery: \_\_\_\_\_  Not Sure  Declined to answer

First prenatal care appointment (date and weeks): \_\_\_\_\_  Not Sure  Declined to answer

Does the member have an OB or midwife?  Yes  No  Declined to answer

Does the member have a doula or do they plan to have a doula?  Yes  No  Declined to answer

Does the member know where they plan to deliver the baby?  Yes  No  Declined to answer

Does the member plan to breastfeed?  Yes  No  Unsure  Declined to answer

Has the member selected a pediatrician for the baby?  Yes  No  Declined to answer

If yes, please fill out the following information:

Name of primary care provider:

Contact number:

Office address:

Does the C/Y member have the essentials they need for when baby comes home from the hospital (e.g. car seat, formula, blankets, crib, clothes, diapers, bottles)?  Yes  No  Declined to answer

If no, list what the member needs:

Does the C/Y member plan to go to any birthing classes?  Yes  No  Declined to answer

Does the C/Y member need education/resources on pregnancy, breastfeeding and infant health?

Yes  No  Declined to answer

**If the C/Y Member has given birth in the last 12 months, the following questions must be completed.  N/A**

Is the C/Y member working with a doula?  Yes  No  Declined to answer

If yes, please fill out the following information:

Name of doula:

Contact number:

Is the C/Y member working with a lactation consultant?  Yes  No  Declined to answer

If yes, please fill out the following information:

Name of consultant:

Contact number:

Has the C/Y member had a postpartum appointment?  Yes  No  Declined to answer

If yes, please fill out the date of the last appointment (if known): \_\_\_\_\_

Has the baby been going to their pediatrician for their appointments?  Yes  No  Declined to answer

If yes, please fill out the following information:  
 Name of provider:  
 Contact number:  
 Office address:  
 Date of last visit (if known, or an approximate date):

Does the C/Y member need education/resources on post-pregnancy and infant health?  
 Yes  No  Declined to answer

**Section 6. Activities of Daily Living (ADLs)**

The following are questions regarding the C/Y member's ability to perform basic self-care activities; complete questions only related to age of child/youth; skip other questions.

Does the C/Y member need help with any of these activities?	
If the C/Y member is age 0-5:	
Eating (as developmentally or age-appropriate – e.g., chewing, swallowing, latch) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Using hands (as developmentally or age-appropriate) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer
Coordination/moving around (as developmentally or age-appropriate) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Toileting (as developmentally or age-appropriate – e.g., potty trained, dry through the night) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Declined to answer
If C/Y member is school-aged (6-18 years old):	
Bathing <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Grooming (brushing teeth & hair, washing hands & face) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer
Dressing <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Eating <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer
Toileting <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Mobility (walking, climbing stairs) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer
If C/Y member is 18+ years old	
Taking a bath or shower <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Going up stairs <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer
Eating <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer	Getting dressed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer
Brushing teeth, brushing hair, shaving <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Making meals or cooking <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer
Getting out of a bed or a chair <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Shopping and getting food <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer
Using the toilet <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Walking <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer
Washing dishes or clothes <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Writing checks or keeping track of money <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer
Getting a ride to the doctor <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Doing house or yard work <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer
Going out to visit family or friends <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	Using the phone <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer
Keeping track of appointments <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer	
Has the member fallen in the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you afraid of falling? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do the member's friends or family members express concerns about their ability to care for themselves? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes to any of the above ADLs, is the C/Y member getting all the help you need with these actions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer Comments:	

<p><b>Does the C/Y member use or need any of the following? (Select all that apply):</b></p> <p><input type="checkbox"/> Devices to help with mobility/transfers (e.g., wheelchair, lifts/seats, grab bar) (list):</p> <p><input type="checkbox"/> Devices to help with feeding/nutrition (e.g., feeding tube, special formula, food supplements) (list):</p> <p><input type="checkbox"/> Devices to help with continence (e.g., catheters, diapers, ostomy supplies) (list):</p> <p><input type="checkbox"/> Devices to help with airway/breathing (e.g., oxygen, ventilator, trach supplies) (list):</p> <p><input type="checkbox"/> Other (list):</p> <p>Does the C/Y (or their parent/guardian/caregiver, if applicable) need help understanding how to use medical equipment?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Declined to answer</p> <p>Comments:</p>
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**Section 7. Psychosocial, Mental, and Behavioral Health**

*The following questions will be used to assess the C/Y member’s current psychosocial, mental, and behavioral health needs and conditions.*

<p>Has a healthcare or mental health provider ever told the C/Y member (or their parent/guardian/caregiver, if applicable) that they have a mental health diagnosis, or emotional or behavioral problem?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer <input type="checkbox"/> N/A due to age of child</p> <p><i>If no, please skip to Social Interactions.</i></p>
<p>If yes, what diagnosis has the C/Y member been given?</p> <p><input type="checkbox"/> Depression <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Psychotic disorder <input type="checkbox"/> Anxiety <input type="checkbox"/> Eating disorder</p> <p><input type="checkbox"/> Other (list):</p> <p>Comments, including how this currently affects the C/Y member’s ability to manage daily activities:</p> <p>Does the C/Y member currently have a provider that is treating them for this diagnosis?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Declined to answer</p> <p>If yes, please fill out the following information:</p> <p style="padding-left: 20px;">Name of provider:</p> <p style="padding-left: 20px;">Contact number:</p> <p style="padding-left: 20px;">Office address:</p> <p>Date of last visit (if known, or an approximate date):</p>

<p><b>Social Interactions</b></p> <p>How often does the C/Y member see or talk to people that they care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)</p> <p><input type="checkbox"/> Less than once a week <input type="checkbox"/> 1 or 2 times a week <input type="checkbox"/> 3 to 5 times a week <input type="checkbox"/> 5 or more times a week</p> <p><input type="checkbox"/> N/A due to age of child/youth <input type="checkbox"/> Decline to answer</p>
<p>Over the past month (30 days), how many days has the C/Y member felt lonely? (Check one.)</p> <p><input type="checkbox"/> None—I never feel lonely <input type="checkbox"/> Less than 5 days <input type="checkbox"/> More than half the days (more than 15)</p> <p><input type="checkbox"/> Most days—I always feel lonely <input type="checkbox"/> N/A due to age of child/youth <input type="checkbox"/> Decline to answer</p>
<p>(If Parent/guardian/caregiver answering) Are they interested in parenting programs about their child’s development?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer</p>

<p><b>Mental/Behavioral Health Assessment Questions</b></p> <p><b>For all C/Y Members:</b></p> <p>Does the C/Y member (or their parent/guardian/caregiver, if applicable) have any concerns about their behavior or mood?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Declined to answer</p> <p>Describe concerns here:</p> <p>Would the C/Y member (or their parent/guardian/caregiver, if applicable) like more information and or receive additional support regarding their mental/behavioral health? If yes, indicate supports requested.</p>
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<b>For C/Y members ages 11 and older</b>
<b>Depression – Patient Health Questionnaire (PHQ-9) – For youth aged 11 and older</b>
<ul style="list-style-type: none"> <li>• <i>If a recent (within past month) PHQ-9 has been completed by another provider and is in chart, enter score here: _____ and date: _____</i></li> <li>• <i>If no PHQ-9 in chart, complete the PHQ-2+Q.9 below</i></li> <li>• <i>Follow scoring guidelines below.</i></li> </ul> <input type="checkbox"/> N/A <input type="checkbox"/> Declined to complete (and reason, if provided):
<b>PHQ-2 plus Question 9</b>
Over the last two weeks, how often have you been bothered by any of the following?
1. Have you experienced a reduction in interest or pleasure in doing things? <input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day
2. Have you felt down, depressed or hopeless? <input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day
3. (Q.9) Thoughts that you would be better off dead or of hurting yourself in some way <input type="checkbox"/> Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day
<b>Scoring: Not at all = 0, Several days = 1, More than half the days = 2, Nearly every day = 3.</b>
<ul style="list-style-type: none"> <li>• <i>For PHQ-2+Q.9: Score of 2 or greater AND/OR checks YES on Q.9 — Individual completes the PHQ-9 (recommend self-administer). Printable PHQ-9 in multiple languages: <a href="https://www.phqscreeners.com/">https://www.phqscreeners.com/</a></i></li> <li>• <i>If PHQ-9 score is &gt;10 consult with clinical consultant and supervisor. If &gt;15 or positive for Q.9 request immediate consultation.</i></li> </ul>
If score indicates risk-factors are present, document actions taken (consultation, referral for mental health assessment):

**Section 8. Substance Use**

The following questions are about the C/Y member’s experience with alcohol, nicotine products, marijuana and other substances. Some of the substances discussed here are prescribed by a doctor, but this part of the assessment will only be focusing on whether the C/Y member has taken them for reasons other than prescribed or in doses other than prescribed.

Declined to Complete     N/A- the C/Y member is too young to complete screening

In the past 6 months, how often has the C/Y member taken the following:							
Substance	Never	1-2 times	Monthly	Weekly	Daily	Date of Last Use	Is this substance use currently a problem for them?
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Nicotine products (cigarette, vaping, chewing tobacco)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Using prescription drugs not as prescribed (circle any relevant): <ul style="list-style-type: none"> <li>• Pain medicines</li> <li>• ADHD medicines</li> <li>• Sleeping pills</li> </ul> Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Other substances: For example, cocaine, meth, heroin, hallucinogens, inhalants, designer drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the C/Y member ever expressed wanting to cut down on drinking or drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Declined to answer							
<b>If yes, the member must complete the following question.</b>							
Would the C/Y member like to talk with someone about their substance use, especially if the member is thinking of quitting or cutting back? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A							
Comments:							



### Section 9. Developmental and Cognitive Functioning

The following questions will be used to assess the C/Y member's current developmental and cognitive health needs and conditions. Only answer questions relevant to the age of the C/Y member.

Has a healthcare provider, mental health provider, or educational professional ever told the C/Y member (or their parent/guardian/caregiver, if applicable) that they have a developmental delay, disability, or brain injury that impacted their cognitive/intellectual functioning, or a neurodevelopmental disorder?

Yes  No  Declined to answer

*If no, skip to age-specific questions.*

If yes, what diagnosis has the C/Y member been given?

Intellectual disability  Developmental disability  Learning disability  ADHD

Autism spectrum disorder

Other (list):

Comments, including how this affects the C/Y member's current ability to manage daily activities:

Does the C/Y member currently have a provider that sees them for the condition(s) described above?

Yes  No  N/A  Declined to answer

If yes, please fill out the following information:

Name of provider:

Contact number:

Office address:

Date of last visit (if known, or an approximate date):

#### **If C/Y member is 0-5**

Is the member enrolled in any early learning programs or in early intervention services?

Yes  No  Declined to answer

If yes, list:

Does the member's parent/guardian/caregiver have any concerns about their child's learning?

Yes  No  Declined to answer

Describe:

Would the parent/guardian/caregiver like more information and to see somebody about their concerns?

#### **If C/Y member is school-aged (6-18)**

Does the member currently receive any treatment, supports or services related to this that are not identified elsewhere on this form (e.g., IEP or 504 Plan)?

Yes; list treatment/supports/services received:

No  N/A  Declined to answer

Does the member (or their parent/guardian/caregiver, if applicable) have concerns about the C/Y member's learning?

Yes  No  Declined to answer

Describe:

Would the C/Y member (or their parent/guardian/caregiver, if applicable) like more information and to see somebody about their concerns?

Educational opportunities and grants:

If the C/Y member is in foster care:  Cal Grant B for Foster Youth  Chafee Foster Youth Grant Program

Other (list):

**If C/Y member is 18+**

Has the Member had any changes in thinking, remembering, or making decisions?

Yes  No  Declined to answer

In the past month, has the member ever felt worried, scared or confused that something may be wrong with their mind or memory?  Yes  No  Declined to answer

**Section 10. Social Determinants of Health (SDoH)**

*The following questions will be used to assess the C/Y member's current social conditions and health-related social needs.*

**Housing**

Where does the C/Y member live? (check all that apply)

House  Apartment complex  Board and care facility  Residential treatment center  Group home  
 Skilled nursing facility  Permanent supported housing  Protective housing  Shared housing (i.e. couch surfing if loss of housing)  Motel/hotel  Trailer park  Campground  Emergency or transitional shelter  Hospitalized with no safe discharge plan  Homeless  Other:  
 Declined to answer

Does the C/Y member feel physically and emotionally safe where they currently live?

Yes  No  Declined to answer

Is the C/Y member (and/or their parent/guardian/caregiver) worried about losing their housing?

Yes  No  Declined to answer

If yes, please explain:

Is anyone currently helping the member (or their parent/guardian/caregiver, if applicable) with their housing support (for example, Housing navigator, case management, or tenants' rights)?  Yes  No  N/A

The C/Y member lives with:  Biological parent  Adoptive parent  Foster parent  Guardian/conservator  
 Caregiver

If time is shared between living spaces, please explain:

How many people live in the C/Y member's household (include ages and relationship to the C/Y member)?

The C/Y member lives alone

Please highlight any other housing concerns that have not been identified above:

**Environmental Safety**

Is the C/Y member and/or parent/guardian/caregiver concerned about living community?  Yes  No  Declined to answer  
 Comments:

Is the C/Y member afraid of anyone or is anyone hurting them?  Yes  No  Declined to answer

If yes, please explain:

Is anyone using the C/Y member's money without their permission?  Yes  No  Declined to answer

If yes, please explain:

C/Y member exposure to substances in the home:

Alcohol  Narcotics  Smoking/vaping/tobacco use  Marijuana  
 Other toxins (describe):  
 Declined to answer

Comments:

Firearms/weapons in the home:  Yes  No  Declined to answer

If yes, how are they stored?

Can the C/Y member live safely and easily around their home?  Yes  No  Declined to answer

Does the place where the C/Y member live have:		
Good lighting: <input type="checkbox"/> Yes <input type="checkbox"/> No	Good heating: <input type="checkbox"/> Yes <input type="checkbox"/> No	Good cooling: <input type="checkbox"/> Yes <input type="checkbox"/> No
Rails for any stairs/ramps: <input type="checkbox"/> Yes <input type="checkbox"/> No	Hot water: <input type="checkbox"/> Yes <input type="checkbox"/> No	Indoor toilet: <input type="checkbox"/> Yes <input type="checkbox"/> No
A door to the outside that locks: <input type="checkbox"/> Yes <input type="checkbox"/> No	Stairs to get into their home or stairs inside their home: <input type="checkbox"/> Yes <input type="checkbox"/> No	Elevator: <input type="checkbox"/> Yes <input type="checkbox"/> No
Space to use a wheelchair: <input type="checkbox"/> Yes <input type="checkbox"/> No	Clear ways to exit their home: <input type="checkbox"/> Yes <input type="checkbox"/> No	Lead paint: <input type="checkbox"/> Yes <input type="checkbox"/> No
Mold/mildew/dampness: <input type="checkbox"/> Yes <input type="checkbox"/> No	Overcrowding: <input type="checkbox"/> Yes <input type="checkbox"/> No	Unreliable utilities: <input type="checkbox"/> Yes <input type="checkbox"/> No
Mice, cockroaches, or other pests: <input type="checkbox"/> Yes <input type="checkbox"/> No	Additional housing and/or home environment safety concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer If yes, please explain:	

**Section 11. Benefits, Other Services, and Access to Necessities**

The following questions will be used to help understand any additional needs to accessing services and supports that the C/Y member may have.

<p><b>Funding/benefit source/services that the C/Y member or the parent/guardian/caregiver (if applicable) uses:</b></p> <p><input type="checkbox"/> CalFresh benefits (SNAP) <input type="checkbox"/> TANF recipient <input type="checkbox"/> School meals <input type="checkbox"/> WIC (list site): _____</p> <p><input type="checkbox"/> SSI/SSDI recipient</p> <p>List any needs:</p>
<p>Does the C/Y member (or their parent/guardian/caregiver, if applicable) sometimes run out of money to pay for any of the following necessities: food, rent, basic utilities, phone and internet, clothing, childcare, medicine or other?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer</p>
<p>Transportation barriers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer</p> <p>If yes, please list:</p>
<p>Childcare barriers: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer</p> <p>If yes, please list:</p>

**Section 12. Legal Involvement**

The following questions will be used to help understand any legal/justice involvement of the C/Y member.

<p><b>In the past 12 months, has the C/Y member been involved with the following?</b></p> <p><input type="checkbox"/> Court ordered services <input type="checkbox"/> On probation <input type="checkbox"/> On parole <input type="checkbox"/> Re-entry program <input type="checkbox"/> DUI/restricted license</p> <p><input type="checkbox"/> Adult Protective Services (APS) <input type="checkbox"/> Child Protective Services (CPS) <input type="checkbox"/> Community legal services</p> <p><input type="checkbox"/> None <input type="checkbox"/> Other (list):</p> <p>Comments, (including any additional legal needs/resources):</p> <p>Does the C/Y member have a re-entry support provider and/or a parole/probation officer?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer</p> <p>If yes, please fill out the following information:</p> <p style="padding-left: 20px;">Name of provider:</p> <p style="padding-left: 20px;">Contact number:</p> <p style="padding-left: 20px;">Office address:</p> <p style="padding-left: 20px;">Date of last visit (if known, or an approximate date):</p>
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**Section 13. End-of-life Planning**

*These questions pertain to the C/Y member if they are 18+*

Does the member have a life-planning document or advance directive in place? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer
Do you want information on these topics? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to answer

**Narrative Summary**

<i>Include primary needs identified from the assessment:</i>	
<b>Next Steps</b>	<b>Person Responsible</b>
1.	
2.	
3.	
Next appointment/location:	