

BEHAVIORAL HEALTH SERVICES

UNIFORM  
CLINICAL RECORDS  
MANUAL

MARCH 2017

# Uniform Clinical Records Manual

## Table of Contents

<b>Section 1</b>	<b><u>CLIENT DATA</u></b>
<b>Section 2</b>	<b><u>ASSESSMENTS</u></b> Behavioral Health Assessments Diagnosis High Risk Assessments Initial Screening Safety Alerts
<b>Section 3</b>	<b><u>OUTCOME EVALUATIONS</u></b>
<b>Section 4</b>	<b><u>PLANS</u></b>
<b>Section 5</b>	<b><u>PROGRESS NOTES</u></b>
<b>Section 6</b>	<b><u>MEDICAL</u></b>
<b>Section 7</b>	<b><u>ADMINISTRATIVE LEGAL</u></b>
<b>Section 8</b>	<b><u>PATHWAYS TO WELL-BEING</u></b>

# CLIENT DATA

## Section 1

# CLIENT FACE SHEET

## COMPLETED BY:

1. The EHR generates this printout based on information entered by each program that has an open assignment of the client. Traditionally this information is entered by program's data entry/clerical staff.

## COMPLIANCE REQUIREMENTS:

1. The Face Sheet should be reviewed in the EHR on a quarterly basis at a minimum to assure all information is accurate and up to date.
2. For clients who are not previously opened in the system the following three forms are to be completed and entered into the EHR:
  - a. Demographic Form
  - b. Assignment Form
  - c. Diagnosis Form
3. For client who are currently or previously opened in the EHR the following form is to be completed and entered:
  - a. Assignment Form
4. Changes in the client's status shall be entered into the EHR as they occur.

## DOCUMENTATION STANDARDS:

1. The Face Sheet is populated by information from the Demographic and Diagnosis Forms as well as from assignment/s entered into the Electronic Health Record (EHR).
2. Since the Face Sheet lives in the EHR, and information on the client is updated in real time as data is entered into the EHR, a paper copy of the Face Sheet is not required to be placed in the paper/hybrid chart.
1. The Demographic, Assignment and Diagnosis Forms must all be completed and entered into the EHR prior to printing the Face Sheet.

# DEMOGRAPHIC FORM

BHS  
UCRM

## COMPLETED BY:

1. Data entry/clerical staff
2. All clinical staff

## COMPLIANCE REQUIREMENTS:

1. Initial Demographic Form shall be completed within 30 days of assignment date to program (day one is counted as the date of assignment).
2. Demographic Forms shall be updated at a minimum of annually and whenever there are updates to be made.
3. All required fields must be complete in order to final approve the form, however it is expected that all fields be addressed.

## DOCUMENTATION STANDARDS:

1. Demographic Forms must be completed on all new client before an assignment can be made.
2. Information may be taken directly from the client, or the clinician may gather information at initial assessment.

**San Diego County Mental Health Services  
Demographic Form**

**Effective Date:** \_\_\_\_\_

**\*Case #:** \_\_\_\_\_

**CLIENT IDENTIFYING INFORMATION**

New (complete all fields)     Update (use RED ink for changes)

<b>Client Name:</b>		
Last Name:	First Name:	
Middle Name:	Suffix:	

<b>Birth Name</b> (if different from above):		
Last Name:	First Name:	
Middle Name:	Suffix:	

<b>Mailing Address &amp; Telephone Number(s):</b>		
Street Address:		
City/State/Zip:	County:	
Home Phone:	*OK to call home?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Work Phone:	Ext:	Cell Phone:

<b>Physical Address</b> (if different from above):		
Street Address:		
City/State/Zip:	County:	

**Social Security #:** \_\_\_\_\_ \* Declines or  Unable to provide Social Security #

**\*Gender:**  M-Male     F-Female     O-Other     U-Unknown    **\*Birth Date:** \_\_\_\_\_  Actual     Estimated

**Born in US:**  Yes     No    If No, Country where born: \_\_\_\_\_

**Born in California:**  Yes If Yes, County where born: \_\_\_\_\_  No If No, State where born: \_\_\_\_\_

**Client Marital Status** (Select one only):  
 1-Never Married     2-Married     4-Divorced     7-Domestic Partner     5-Separated     3-Widowed     6-Unknown

**Ethnicity** (select one only):  
 1-Not Hispanic     2-Hispanic – Mexican American/Chicano     3-Hispanic – Cuban     4-Hispanic – Puerto Rican  
 6-Hispanic – Dominican     7-Hispanic – Salvadoran     5-Hispanic – Other/Latino     9-Unknown/Not Reported

**Race Rank 1 to 5 as needed with 1 being primary:**

A-White/Caucasian	J-Japanese	S-Samoan
B-Black/African American	K-Korean	T-Sudanese
C-Cambodian	L-Laotian	U-Chaldean
D-Chinese	M-Mien	V-Vietnamese
E-Eskimo/Alaskan Native	N-Native American	W-Ethiopian
F-Filipino	O-Other Non-White/ Non-Caucasian	X-Somali
G-Guamanian	P-Other Pacific Islander	Y-Iranian
H-Hawaiian Native	Q-Hmong	Z-Iraqi
I-Asian Indian	R-Other Asian	9-Unknown/Not Reported

**Language** (Complete both client languages. If there is a caretaker, complete caretaker language)

Client Primary: \_\_\_\_\_ Client Preferred: \_\_\_\_\_ Caretaker Preferred: \_\_\_\_\_

Interpreter Needed?  Yes     No    (If either preferred language is other than English, an interpreter is needed)

**Employment Status** (Check only one value. Starting with "A" check the first one that applies to client):

<input type="checkbox"/> A-Comp Job 35+ hrs per week	<input type="checkbox"/> G-Full Time Job Training	<input type="checkbox"/> M-Retired
<input type="checkbox"/> B-Comp Job 20-34 hrs per week	<input type="checkbox"/> H-Part time Job Training	<input type="checkbox"/> N-Unemployed/Seeking Work
<input type="checkbox"/> C-Comp Job < 20 hrs per wk	<input type="checkbox"/> I-Full Time Student	<input type="checkbox"/> O-Unemployed/Not Seeking Work
<input type="checkbox"/> D-Rehab 35+ hrs per wk	<input type="checkbox"/> J-Part Time Student	<input type="checkbox"/> P-Not in the Labor Force
<input type="checkbox"/> E-Rehab 20-34 hrs per wk	<input type="checkbox"/> K-Volunteer	<input type="checkbox"/> Q-Resident/Inmate
<input type="checkbox"/> F-Rehab < 20 hrs per wk	<input type="checkbox"/> L-Homemaker	<input type="checkbox"/> U-Unknown

**Living Arrangement** (Check only one value from the list below):

<input type="checkbox"/> A-House or Apartment	<input type="checkbox"/> I-MH Rehab Ctr (Adult Locked)	<input type="checkbox"/> S-Group Home-Child (Level 1-12)
<input type="checkbox"/> B-House or Apt with Support	<input type="checkbox"/> J-SNF/ICF/IMD	<input type="checkbox"/> T-Residential Tx Ctr-Child (Level 13-14)
<input type="checkbox"/> C-House or Apt with Daily Supervision Independent Living Facility	<input type="checkbox"/> K-Inpatient Psych Hospital	<input type="checkbox"/> U-Unknown
<input type="checkbox"/> D-Other Supported Housing Program	<input type="checkbox"/> L-State Hospital	<input type="checkbox"/> V-Comm Tx Facility (Child Locked)
<input type="checkbox"/> E-Board & Care – Adult	<input type="checkbox"/> M-Correctional Facility	<input type="checkbox"/> W- Children’s Shelter
<input type="checkbox"/> F-Residential Tx/Crisis Ctr – Adult	<input type="checkbox"/> O-Other	<input type="checkbox"/> XX-Homeless/In Shelter
<input type="checkbox"/> G-Substance Abuse Residential Rehab Ctr	<input type="checkbox"/> R-Foster Home-Child	<input type="checkbox"/> YY-Homeless/Out of Shelter
		<input type="checkbox"/> ZZ-Homeless/Living w Other(s)

**San Diego County Mental Health Services  
Demographic Form – Page 2**

<b>Client Name:</b>	<b>Case Number:</b>
*Currently Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Number of children less than 18 years of age that the client cares for at least 50% of the time:	
Number of adults 18 years or older that the client cares for at least 50% of the time:	

<b>Education</b> (last grade or years completed):	<b>Religion:</b>
*Does the client have Regional Center involvement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refuse/Cannot Access	
*Military Service: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline <input type="checkbox"/> Unable to Answer	<b>Branch:</b>
If 18, has client been offered the National Voter's Registration form? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline	
<b>Mother's First Name:</b>	

**ALIAS(ES)** (List other names you have used. A first & last name must be included for each alias)

Last Name:	First Name:	Middle Initial:

**LEGAL INFORMATION/LEGAL CONSENT** (check only one box in the lists below):

<p align="center"><b>Self Consent</b> <i>Legal Rep Information not required</i></p> <input type="checkbox"/> A-Adult / Self Consent <input type="checkbox"/> E-Minor / Self Consent <input type="checkbox"/> D-Emancipated Minor	<p align="center"><b>Conservator</b></p> <input type="checkbox"/> I-Temporary <input type="checkbox"/> J-Permanent <input type="checkbox"/> K-Murphy <input type="checkbox"/> L-Probate	<p align="center"><b>Minor</b></p> <input type="checkbox"/> B-Parental Consent <input type="checkbox"/> C-Guardian/Caregiver	<p align="center"><b>Juvenile Court</b></p> <input type="checkbox"/> F-Dependent <input type="checkbox"/> G-Ward Status Offender <input type="checkbox"/> H-Ward Juvenile Offender
Legal Representative:		Relationship:	
Address:		Phone:	
City/State/Zip:			
Employment Phone:		Other Information:	

**PARENTAL & SCHOOL INFORMATION**

**Is client under 18:**  **Yes** (School & Parental Information required)  **No** (Parental information is optional)

Parent Name:	Relationship:
Address:	Phone:
City/State/Zip:	
Employment Phone:	Other Information:
School Attending:	
School District of Residence:	

**JUVENILE FORENSICS**

REJIS #:
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**EMERGENCY NOTIFICATION INFORMATION**

Name:	Relationship:
Address:	Home Phone:
City/State/Zip:	Work Phone:
Other Information:	

**CONTACTS**

Name (Last, First MI)	Agency/Title/Relationship	Phone

**Staff Completing/Accepting the Assessment:**

Signature	Printed Name	Cerner ID	Date
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# DISCHARGE SUMMARY

## COMPLETED BY:

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Nurse Practitioner/Physician Assistant
6. Registered Nurse\*
7. Licensed Psychiatric Technician/Vocational Nurse\*
8. Registered PsyD and Trainee\*

## COMPLIANCE REQUIREMENTS:

1. A discharge summary is completed when the client has been seen for five or more services during treatment.
2. When client has been seen four or less times during treatment, a discharge note is sufficient.
3. The discharge summary must be completed 7 days from the date of discharge (with day 1 being the date of closing assignment from the program).
4. All fields must be completed or marked N/A.
5. Title 9 Medical Necessity Criteria shall be substantiated.
6. Title 9 Included Diagnosis shall be substantiated.

## DOCUMENTATION STANDARDS:

1. Co-signatures must be completed prior to final approval of discharge summary.
2. CYF SOC
  - a. Only licensed, registered, waived clinical staff may conduct and claim for discharge summary (exceptions: Registered PsyD/PhD cannot complete).
3. \*A/OA SOC
  - a. \*RNs, MHRS, LPT, Registered PsyD/PhD and Trainee may not diagnose a mental illness due to scope of practice, but may conduct and claim for discharge summary with co-signature of licensed/registered/waivered staff. Therefore a stand-alone diagnosis form shall be completed by a qualified provider prior to completion of discharge summary.
4. Include unit/subunit/date in text fields to denote program specific entry.
5. When the discharge summary is not completed and final approved the system will prevent other servers from launching any assessments that contain shared fields. A discharge summary that is not final approved is at risk for deletion by another server.
6. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible.
7. A discharge summary is not valid until it is thoroughly completed and final approved with all required signatures.

**San Diego County Mental Health Services  
DISCHARGE SUMMARY**

**\*Client Name:**

**\*Case #:**

**\*Discharge Date:**

**\*Program Name:**

\*Date of admission:

**\*REASON FOR ADMISSION** *Describe events in sequence leading to admission to your program.  
Describe primary complaint upon admission.*

**COURSE OF TREATMENT**

\*Client Plan goal(s) were met?

No     Yes     Partially     Client did not return

\*Discharge Reason:

Significant diagnostic changes during treatment:     No     Yes

Summary of Services: *Response to treatment/progress, and reason for discharge.*

Aftercare Plan: *Information provided to client/family at discharge and recommendations.*

Housing/Living arrangements at discharge: *(Select from Living Arrangement table in Drop Down menu)*

Substance use treatment recommendations:     Not Applicable     Yes

**MEDICAL HISTORY:**

Medications at Discharge:

Medication Adherence     Always     Sometimes     Rarely     Never     Unknown

Comments:

Allergies and adverse medication reactions:     No     Unknown/Not Reported     Yes

**Client Name:**

**Case #:**

**Discharge Date:**

**Program Name:**

If yes, specify:

Other prescription medications:  None  Yes

If yes, specify:

Herbal/Dietary Supplements/over the counter medications:  None  Yes

If yes, specify:

Healing and Health:

**HISTORY OF VIOLENCE:**

History of domestic violence:  None reported  Yes

History of significant property destruction:  None reported  Yes

History of violence:  None reported  Yes  
*Specify type, intensity, and if past or current.*

History of abuse:  None reported  Yes  
*Specify type, intensity, and if past or current.*

Abuse reported:  N/A  No  Yes

If Yes, specify:

Experience of traumatic event[s]:  
 No  Yes  Unknown/not reported

If Yes: *Describe traumatic experience and summarize impact.*

**Client Name:**

**Case #:**

**Discharge Date:**

**Program Name:**

**REFERRAL(S):** *Include culturally specific referral(s), referred to a higher level of care, referred to a lower level of care, referred to primary care physician for psychotropic medication, or reason why no referrals were provided, etc.*

\*Referred to:

If Other, Specify:

Appointment Date:

Time:

Client or caregiver declined referral(s)

**Signature of Clinician Requiring Co-signature:**

\_\_\_\_\_ Date:  
Signature

Printed Name:

Anasazi ID number:

**\*Signature of Clinician Completing/Accepting the Assessment:**

\_\_\_\_\_ Date:  
Signature

Printed Name:

Anasazi ID number:

**Signature of Staff Entering Information (if different from above):**

\_\_\_\_\_ Date:  
Signature

Printed Name:

Anasazi ID number:

**DIAGNOSIS**

**If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Discharge Summary**

**San Diego County Mental Health Services  
Discharge Summary  
Instructions**

**Client Name:** This is a Required Field. Enter the client’s name in this space provided.

**Case #:** This is a Required Field. Enter the case number in the space provided.

**Program Name:** This is a Required Field. Enter your unit name and number in the space provided.

**Date of admission:** This is a Required Field. Enter the information in the space provided.

**Date of discharge:** This is a Required Field. Enter the information in the space provided.

**REASON FOR ADMISSION:** This is a Required Field. Describe events in sequence leading to admission to your program. Describe primary complaint upon admission.

**COURSE OF TREATMENT:** Answer question regarding client plan goals by selecting the appropriate check boxes.

Discharge Reason: Enter a reason for discharge by selecting from the Table Below:

<p><b>Reason for Discharge</b>            1-Transferred to a Higher Level of Care            2-Transferred to Same Level of Care            3-Transferred to Lower Level of Care            4-Satisfactorily Achieved Goals            5-Incarcerated            6-Moved Away from Service Area            7-Client/Family Dissatisfied</p>	<p>8-Deceased            9-Patient Left Against medical Advice            10-Client/Family Did Not Return            11-Client Receiving Services/Tx Elsewhere            12-Change in Medical Insurance            13-Transferred for Medical Reasons            14-Other</p>
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For Other, Specify reason.

For significant diagnostic changes select “No” or “Yes” text box is provided for further information. Summary of services text box is provided to record response to treatment/progress and reason for discharge.

Aftercare Plan: Text box is provided for information provided to client/family at discharge and recommendation.

Housing/Living Arrangements at discharge: Entering the appropriate response in the space provided from choices listed in the Table below:

<b>Living Arrangement</b>		
A-House or Apartment	G-Substance Abuse Residential	O-Other
B-House or Apt with Support	Rehab Ctr	R-Foster Home-Child
C-House or Apt with Daily Supervision	H-Homeless/In Shelter	S-Group Home-Child (Level 1-12)
Independent Living Facility	I-MH Rehab Ctr (Adult Locked)	T-Residential Tx Ctr-Child (Level 13-14)
D-Other Supported Housing Program	J-SNF/ICF/IMD	U-Unknown
E-Board & Care – Adult	K-Inpatient Psych Hospital	V-Comm Tx Facility (Child Locked)
F-Residential Tx/Crisis Ctr – Adult	L-State Hospital	W- Children’s Shelter
	M-Correctional Facility	

Substance use treatment recommendations: Check boxes “Not Applicable” or “Yes” text box is provided for further information.

**MEDICAL HISTORY**

Medications at Discharge: List all medications dispensed or ordered at discharge.

Medication Adherence: Check the appropriate box, and explain in Comments text box as necessary client’s compliance with medications.

Allergies and adverse medication reactions: Check “No”, “Unknown/Nor Reported” or “Yes”. If Yes, specify in comments box.

Other prescription medications: Check “None” or “Yes”. If yes, specify in comments box.

Herbal/Dietary Supplements/over the counter medications: Check “None” or “Yes”. If Yes, specify in comments box.

Healing and Health: Document in text box any healing and/or health practices made by client.

**HISTORY OF VIOLENCE:**

History of domestic violence: Check boxes “None Reported” or “Yes” text box is provided for further information.

History of significant property destruction: Check boxes “None Reported” or “Yes” text box is provided for further information.

History of Violence: Check boxes “None Reported” or “Yes” in text box specify intensity past or current.

History of Abuse: Check boxes “None Reported” or “Yes” in text box specify intensity past or current.

Abuse Reported: Check boxes “N/A”, “No” or “Yes”, if yes enter information in text box.

Experience of traumatic event(s): Check boxes “No” “Yes” “Unknown/Not Reported” if yes, describe traumatic experience and summarize impact in text box.

**REFERRAL(S):** Include culturally specific referral(s), referred to a higher level of care, referred to a lower level of care, referred to primary care physician for psychotropic medication, or reason why no referrals were provided, etc.

Referred To: This is a required field. Select from Table below specific referrals.

<b>Referred To:</b> 1-ACT Program 2-ACL,211,or Other Community Support 3-CAPS 4-Case Management Program 5-Clubhouse	6-FFS Hospital 7-FFS Provider 8-Mental Health Res Treatment Facility 9-OP Clinic 10-PEI Program 11-Primary Care Provider/FQHC	12-SDCPH 13-Substance Abuse Treatment – OP 14-Substance Abuse Tx – Residential 15-TBS 16-Other 18-None
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If Other, Specify in this field.

In the text boxes enter the appointment date and time, if available. Check the box if client or caregiver declined referral(s).

**SIGNATURES:** Enter the name, credential, date and Anasazi ID number for the clinician requiring a co-signature (if applicable); and/or the clinician completing/accepting the evaluation.

**DIAGNOSIS**

**If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Discharge Summary.**

# ASSESSMENTS

## Section 2

**County of San Diego Mental Health Services  
BEHAVIORAL HEALTH ASSESSMENT – ADULT**

**\*Client Name:**

**\*Case #:**

**\*Assessment Date**

**\*Program Name:**

**BHA ADULT TAB**

**LEGAL STATUS/CASE MANAGER/PAYEE**

Conservator:             None             LPS             Probate             Temporary

Case Manager:  None             SBCM             FSP             Institutional  
 Regional Center             Other

Payee:

Probation Officer:

**\*SOURCE OF INFORMATION:** *Select from Source of Information table listed on the Instructions Sheet*

If a source other than listed on the “Source of Information” table, specify:

Reports Reviewed:

*\*Referral Source: Select from Referral Source Table listed on the Instructions Sheet*

If Other, specify:

**PRESENTING PROBLEMS/NEEDS:** *(Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and history of present illness. Summary of client’s request for services including client’s most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors; include experiences of stigma and prejudice, if any)*

**PAST PSYCHIATRIC HISTORY:** *(History of symptoms and/or mental health treatment. Describe in chronological order - where, when, and length of time. Include dates and providers related to any prior psychiatric treatment, history, traumatic and/or significant events, and/or trauma related to treatment. Include the most recent periods of stability and the characteristics of those periods)*

**FAMILY HISTORY:**

Living Arrangement: *Select from Living Arrangement table listed in the Instructions Sheet*

Those living in the home with client:

Have any relatives ever been impacted by the following:

*(Select from Relatives table listed in the Instructions Sheet):* Expand below if applicable.

Suicidal thoughts, attempts:

Violence:

Domestic violence:

Substance abuse or addiction:

Other addictions:

Gang involvement:

Emotional/mental health issues:

Physical health conditions:

Intellectual developmental disorder:

Developmental delays:

Arrests:

Abuse:

Abuse reported:  N/A  No  Yes  Refuse/Cannot Assess

Include relevant family information impacting the client:

Family strengths:

**EDUCATION:**

Area of Concerns:  Academic  
 Behavioral  
 Social  
 No issue reported  
 Other:

Last grade completed:

Failed the following grade(s):

Client has an active 504 Plan:  No  Yes  Refuse/Cannot Assess

Client has an active IEP:  No  Yes  Refuse/Cannot Assess

Special Education:  No  Yes  Refuse/Cannot Assess

Is Client receiving mental health services through a school district?  No  Yes  Refuse/Cannot Assess

Describe:

Educational Strengths:

**EMPLOYMENT:**  Does not apply

History of volunteer/community service:  No  Yes  Refuse/Cannot Assess

History of work experience:  No  Yes  Refuse/Cannot Assess

Current work experience:  No  Yes  Refuse/Cannot Assess

Last date worked:

Area of Concerns:  Skills Readiness  
 Barriers  
 Training  
 Job retention  
 No issue reported/NA  
 Other:

Describe:

Employment Strengths:

**SOCIAL CONCERNS:**

Peer/Social Support  No  Yes  Refuse/Cannot Assess

Substance use by peers  No  Yes  Refuse/Cannot Assess

Gang affiliations  No  Yes  Refuse/Cannot Assess

Family/community support system  No  Yes  Refuse/Cannot Assess

Religious/spirituality  No  Yes  Refuse/Cannot Assess

\*Justice system  No  Yes  Refuse/Cannot Assess

A YES response to any of the above requires detailed documentation:

**MILITARY HISTORY:**

Branch: Date of Service:  
Discharge status:  
Impact of service/combat history:

**CULTURAL INFORMATION:** *(Considerations could include language of client/family, primary language spoken at home, religious, spiritual beliefs, family structures, customs, moral/legal systems, life-style changes, socio-economic background, ethnicity, race, immigration history/experience, age, and subculture (homelessness, gang affiliations, substance use, foster care, military background), exposure to violence, abuse and neglect, experience with racism, discrimination, and social exclusion. Describe unique cultural and linguistic needs and strengths that may impact treatment. Cultural information includes an understanding of how client’s mental health is impacted. Consider using the Cultural Formulation Interview in the DSM 5 for further guidance).*

Experience of stigma, prejudice, barriers to accessing services:  No  Yes  Refuse/Cannot Assess

Describe:

**SEXUAL ORIENTATION:** *(Help Text see Appendix A)*

Select all that apply:

Heterosexual/Straight  Bisexual  Lesbian  Gay  Queer  
 Another sexual orientation  Questioning/Unsure  Decline to state

**GENDER IDENTITY:** *(Help Text see Appendix A)*

Assigned at birth (Select one):  Male  Female  Decline to state

Current Gender (Select all that apply):

Male  Female  Transgender  Genderqueer  
 Another gender identity  Questioning/Unsure  Decline to state

Clinical Considerations:

**HISTORY OF SELF-INJURY/SUICIDE/VIOLENCE:**

History of self-injury (cutting, burning)  No  Yes  Refuse/Cannot Assess  
History of suicide attempt/s:  No  Yes  Refuse/Cannot Assess  
History of violence toward another:  No  Yes  Refuse/Cannot Assess  
History of significant property destruction:  No  Yes  Refuse/Cannot Assess  
History of domestic violence:  No  Yes  Refuse/Cannot Assess  
History of abuse:  No  Yes  Refuse/Cannot Assess

Abuse reported:  N/A  
 Experience of traumatic event/s:

No  Yes  Refuse/Cannot Assess  
 No  Yes  Refuse/Cannot Assess

A YES or refuse/cannot assess response to any of the above requires detailed documentation:

**SUBSTANCE USE INFORMATION:**

Have you ever used tobacco/nicotine products?  No  Yes  Refuse/Cannot Assess

At what age did you first use tobacco/nicotine products:

Smoker Status: (Select value from drop down list)

In the past 30 days, what tobacco product did you use most frequently?

What age did you stop using tobacco/nicotine products?

Has the client been informed of the risks? (Smoking is a serious health risk that leads to cancer, cardiovascular disease and possibility of premature death)  No  Yes  Refuse/Cannot Assess

Have Smoking Cessation Resources been offered?  No  Yes  Refuse/Cannot Assess

History of Substance Use?  No  Yes  Refuse/Cannot Assess

(if yes, specify substances used)

Name of Drug	Priority	Method of Administration	Age 1 <sup>st</sup> used	Freq- uency of Use	Days of use in last 30 days	Date of last use	Amount of last use	Amount used on a typical Day	Largest Amount Used in One Day

History of substance use treatment: (Types of treatment, level of care, length of treatment, etc.)

Does client have a co-occurring disorder (COD):  No  Yes  Refuse/Cannot Assess

**Quadrant:** (Indicate mental health and substance abuse level of need.)

Q. I: Low / Low  Q. II: High / Low  
 Q. III: Low / High  Q. IV: High / High

**Stages of Change: Substance Abuse Recovery**

Pre-Contemplation  Contemplation  
 Preparation/Determination  Action  
 Maintenance  Not applicable

When applicable, describe how substance use impacts current level of functioning:

Recommendation for further substance use treatment:  No  Yes  Not applicable

If Yes:

**Gambling:**

Have you ever felt the need to bet more and more money?  No  Yes  Refuse/Cannot Assess

Have you ever had to lie to people important to you about how much you gambled?  No  Yes  Refuse/Cannot Assess

If Yes:

**HIGH RISK ASSESSMENT TAB**

**ASSESSMENT OF IMMEDIATE RISK FACTORS:** Any “yes” response triggers enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session.

Direct (past 2 weeks) discharge from 24 hour program *due to suicidal or homicidal crisis* (hospital, IMD, START, residential treatment, etc.)  No  Yes  Refuse/Cannot Assess

Current serious thoughts/impulses of hurting/killing self or others:  No  Yes  Refuse/Cannot Assess  
*Note if access to fire arms (guns) or other lethal means:*

Pre-death behavior/committed to dying (e.g. giving away possessions) and/or current hopelessness/sees no options  No  Yes  Refuse/Cannot Assess

Preoccupied with incapacitating or life threatening illness and/or chronic intractable pain and/or catastrophic social loss  No  Yes  Refuse/Cannot Assess

Current command hallucinations, intense paranoid delusions and/or command override symptoms (belief that others control thoughts/actions)  No  Yes  Refuse/Cannot Assess

Current behavioral dyscontrol with intense anger/humiliation, recklessness, risk taking, self-injury and/or physical aggression and violence  No  Yes  Refuse/Cannot Assess

**Additional Youth Risk Factors:**

Current extreme social alienation, isolation and/or victim of bullying  No  Yes  Refuse/Cannot Assess

A YES or REFUSE/CANNOT Assess response to any of the above requires detailed documentation:

**PROTECTIVE FACTORS:** (strong religious, cultural, or inherent values against harming self/others, strong social support system, positive planning for future, engagement in treatment, valued care giving role (people or pets) and strong attachment/responsibility to others.)

**SELF-INJURY/SUICIDE/VIOLENCE MANAGEMENT PLAN:** (Document enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. For all unlicensed staff,

documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session.)

**TARASOFF ASSESSMENT:**

**Current Violent Impulses and/or Homicidal ideation toward a reasonably identified victim?**

No  Yes  Refuse/Cannot Assess

Tarasoff Warning Indicated?

No  Yes

*If yes, include victim(s) name and contact information (Tarasoff Warning Details):*

Reported To:                      Date:

**CURRENT DOMESTIC VIOLENCE?**

No  Yes  Refuse/Cannot Assess

*If yes, detailed documentation and child/adult protective services question mandatory. Describe situation:*

Child/Adult Protective Services Notification Indicated?

No  Yes

Reported To:                      Date:

**MEDICAL TAB**

**ALLERGIES AND ADVERSE MEDICATION REACTIONS:**  No  Yes  Unknown/Not Reported

If Yes, specify:

(Share this allergy information with your medical staff.)

Medications are recorded in the Doctors Home Page (DHP)

Does client have a Primary Care Physician?

No  Yes  Unknown

If No, has client been advised to seek primary care?

No  Yes

Primary Care Physician:

Phone Number:

Seen within the last:  6 months  12 months  Other:

Hospital of choice (physical health):

Have you ever been hospitalized for any major illness?

No  Yes  Refuse/Cannot Assess

Have you ever had an operation?

No  Yes  Refuse/Cannot Assess

Have you had any complications from a childhood disease?

No  Yes  Refuse/Cannot Assess

Has sleep been a problem?

No  Yes  Refuse/Cannot Assess

Has there been a change in appetite?

No  Yes  Refuse/Cannot Assess

A YES or REFUSE/CANNOT assess response to any of the above requires detailed documentation:

Been seen for the following (provide dates of last exam):

Dental exam:

Hearing exam:

Vision exam:

Physical Health issues: None at this time Yes

If Yes, specify:

Is condition followed by Primary Care Physician? No Yes N/A  
Physical health problems affecting mental health functioning:

Head injuries: No Yes

If Yes, specify:

Medical and/or adaptive devices:

Significant Developmental Information (when applicable):

Healing and Health: *(Alternative healing practice and beliefs. Apart from mental health professionals, who or what helps client deal with disability/illness and/or to address substance use issues? Describe.)*

## **FUNCTIONAL ASSESSMENT TAB**

Personal care skills:

Activities daily living:

Community living skills:

Social skills:

Community educational/work activities:

Somatic safety:

Careless smoking AWOL Assault Fire setting  
Inappropriate sexual behavior

Basic self-care:

Incontinence Other

Housing at risk:  No  Yes

Recent Deaths:

Death Anniversaries:

Decision Maker:

Name: Relationship:

Family level of involvement:  Very High  High  Medium  Low

Primary caregiver:

Caregiver resources known of/used:

Caregiver burden level:  Mild  Moderate  Severe

**ILLNESS MANAGEMENT:**

Access to treatment (transportation):  Yes  No  
Knowledge of mental health status:  Yes  No  
Engagement in treatment:  Yes  No  
Knowledge of illness:  Yes  No

**RECOMMENDATIONS:**

Services:

Acute Inpatient  Partial Hospital Day Treatment  
 Individual/Group Therapy  Case Management  
 Psycho-social/Educational Activities  Other

Living Situation:

Independent living  Assisted living  
 Residential  SNF  
 Other

**MENTAL STATUS EXAM TAB**

Unable to assess at this time.

Level of Consciousness

Alert  Lethargic  Stuporous

Orientation

Person  Place  Day  Month  Year  Current Situation  
 All Normal  None

Appearance

Good Hygiene  Poor Hygiene  Malodorous  Disheveled  
 Reddened Eyes  Normal Weight  Overweight  Underweight

Speech

Normal  Slurred  Loud  Soft  Pressured  Slow  Mute

Thought Process

Coherent  Tangential  Circumstantial  Incoherent  Loose Association

Behavior

Cooperative  Evasive  Uncooperative  Threatening  Agitated  Combative

Affect

Appropriate  Restricted  Blunted  Flat  Labile  Other

Intellect

Average  Below Average  Above Average  Poor Vocabulary  
 Poor Abstraction  Paucity of Knowledge  Unable to Rate

Mood

Euthymic  Elevated  Euphoric  Irritable  Depressed  Anxious

Memory

Normal  Poor Recent  Poor Remote  Inability to Concentrate  
 Confabulation  Amnesia

Motor

- Age Appropriate/Normal     Slowed/Decreased     Psychomotor Retardation
- Hyperactive     Agitated     Tremors     Tics     Repetitive Motions

Judgment

- Age Appropriate/Normal     Poor     Unrealistic
- Fair     Limited     Unable to Rate

Insight

- Age Appropriate/Normal     Poor     Fair     Limited     Adequate     Marginal

Command Hallucinations

- No     Yes, specify:

Auditory Hallucinations

- No     Yes, specify:

Visual Hallucinations

- No     Yes, specify:

Tactile Hallucinations

- No     Yes, specify:

Olfactory Hallucinations

- No     Yes, specify:

Delusions

- No     Yes, specify:

Other observations/comments when applicable :

**CASE MANAGEMENT TAB**

- Does not apply to program services

STRENGTHS/SUPPORT SYSTEMS: *(Describe how each resource is supportive with recovery. List important persons and/or groups involved in support.)*

Strengths Model is protected by Copyright (Charles A. Rapp, Ph.D. at the University of Kansas.) Used by San Diego County Mental Health Services with permission.

Daily Living Situation

Current Status *(What is going on today? What is available now?)*

Client's Desires and Aspirations *(What do I want?)*

Resources – Social and Personal *(What have I used in the past?)*

Financial/Insurance

Current Status *(What is going on today? What is available now?)*

Client's Desires and Aspirations *(What do I want?)*

Resources – Social and Personal *(What have I used in the past?)*

Vocational/Educational

Current Status *(What is going on today? What is available now?)*

Client's Desires and Aspirations *(What do I want?)*

Resources – Social and Personal *(What have I used in the past?)*

Social Supports

Current Status *(What is going on today? What is available now?)*

Client's Desires and Aspirations *(What do I want?)*

Resources – Social and Personal *(What have I used in the past?)*

Health

Current Status *(What is going on today? What is available now?)*

Client's Desires and Aspirations *(What do I want?)*

Resources – Social and Personal *(What have I used in the past?)*

Leisure/Recreational

Current Status *(What is going on today? What is available now?)*

Client's Desires and Aspirations *(What do I want?)*

Resources – Social and Personal *(What have I used in the past?)*

Spiritual/Cultural

Current Status *(What is going on today? What is available now?)*

Client's Desires and Aspirations *(What do I want?)*

Resources – Social and Personal *(What have I used in the past?)*

Client Priorities *(How does the client prioritize the areas above in importance?)*

**BHA SIGNATURE PAGE TAB**

**Stages of Change: Mental Health Recovery**

- |  |   |
|--|---|
| <input type="checkbox"/> Pre-Contemplation         | <input type="checkbox"/> Contemplation  |
| <input type="checkbox"/> Preparation/Determination | <input type="checkbox"/> Action         |
| <input type="checkbox"/> Maintenance               | <input type="checkbox"/> Not applicable |

**CLINICAL FORMULATION:** *(Justification for diagnosis and medical necessity. Summarize and integrate all information gathered from other sources to render clinical judgment regarding intensity, length of treatment and recommendations for service. Clearly state those emotional or behavioral symptoms that interfere with normal functioning. Include evaluation of client's ability and willingness to solve the presenting problems, address both mental health and substance issues from an integrated perspective.)*

**MEDICAL NECESSITY MET:**  No  Yes

When "No," note date NOA-A issued [Medi-Cal clients only]:

CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE? Yes Date:

Local mental health program shall inform Clients receiving mental health services, including parents or guardians of children / adolescents, verbally or in writing that:

- Acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services;
- They retain the right to access other Medi-Cal or Short Doyle/Medi-Cal reimbursable services and have the right to request a change of provider, staff person, therapist, and/or case manager.
- Guide to Medi-Cal Mental Health Services was explained and offered on:**
- Grievance and Appeal Process explained and Brochure with form fill and envelope offered on:**
- Provider List explained and offered on:**
- Mental Health Plan's Notice of Privacy Practices (NPP) was offered on:**
- Language/Interpretation services availability reviewed and offered when applicable on:**
- Advanced Directive brochure was offered on:**
- Voter registration material was offered to client at intake or change of address:**

Signature of Clinician Requiring Co-signature:

\_\_\_\_\_  
Signature

Date:

Printed Name                      Cerner ID number:

\*Signature of Clinician Completing/Accepting the Assessment:

\_\_\_\_\_  
Signature

Date:

Printed Name                      Cerner ID number:

## Appendix A:

### *Sexual orientation:*

*The type of sexual, romantic, and/or physical attraction someone feels towards others. Who a person is primarily attracted to physically, romantically, and/or emotionally, for example, males, females, both, neither; enduring emotional, romantic or sexual attraction to other people. One's sexual behavior affects the choices one makes in responding to sexual orientation. It is the attraction that shapes one's orientation.)*

*Another sexual orientation: not attracted to either female or male; can refer to a person who is asexual and does not have a sexual attraction or desire to any group of people. Asexuality is not the same as celibacy.*

*Bisexual: is romantic attraction, sexual attraction, or sexual behavior toward both males and females or romantic or sexual attraction to people of any sex of gender identity. A person who is "bi" may not have had an equal amount of sexual experiences with people of the same sex*

*Decline to state: client may be unsure or unwilling to disclose*

*Gay: emotionally, romantically, and/or physically attracted to people of the same sex; although it can be used for any sex (e.g., gay man, gay woman, gay person), "lesbian" is sometimes the preferred term for women who are attracted to women; a gay person may not have had any sexual experience; it is the attraction that shapes sexual orientation.*

*Heterosexual/straight: emotionally, romantically, and/or physically attracted to people of the opposite gender.*

*Lesbian: a woman who is emotionally, romantically, and/or physically attracted to other women; women may also use the term gay to describe themselves; a gay or lesbian woman may not have had any sexual experience.*

*Queer: Think of queer as an umbrella term. It includes anyone who: a) wants to identify as queer and b) who feels somehow outside the societal norm in regards to gender or sexuality. This therefore, could include the person who highly values queer theory concepts and would rather not identify with any particular label, the gender fluid bisexual, the gender fluid heterosexual, the questioning LGBT person, and the person who just doesn't feel like they quite fit in to societal norms and wants to bond with a community over that. Originally pejorative for gay; this term has been reclaimed by some gay men, lesbians, bisexuals and transgendered persons as a self-affirming umbrella term. It is a fluid label as opposed to a solid label.*

*Questioning/Unsure: exploring sexual orientation, gender identity, gender expression)*

### *Gender Identity:*

*The sense of "being" male, female, genderqueer, agender, etc. For some people, gender identity is in accord with physical anatomy. For transgender people, gender identity may differ from physical anatomy or expected societal roles. It is important to note that gender identity, biological sex, and sexual orientation are separate and that you cannot assume how someone identifies in one category based on they identify in another category.)*

*Another gender identity: some of both male and female or neither; refer to genderqueer for more information*

*Genderqueer: Genderqueer is most commonly used to describe a person who feels that his/her gender identity does not fit into the socially constructed "norms" associated with his/her biological sex. Genderqueer identities can include one or more of the following: both man and woman, neither man or woman [genderless], moving between genders [gender fluid], third gender or other gender, those who do not or cannot place a name to their gender, and having an overlap of, or blurred lines between gender identity and sexual orientation.*

*Questioning/unsure: exploring sexual orientation, gender identity, gender expression*

*Transgender: It is frequently used as an umbrella term to refer to people who do not identify with their assigned gender at birth. This includes transsexuals, cross-dressers, genderqueer, drag kings, two spirit people and others. Some transgender people feel like they exist not within one of the two standard gender categories, but rather somewhere in between, beyond, or outside of those two genders.*

**San Diego County Mental Health Services  
BEHAVIORAL HEALTH ASSESSMENT - ADULT  
Instructions**

**CLIENT NAME:** Required Field

**CASE #-** Required Field.

**ASSESSMENT DATE:** Required Field

**PROGRAM NAME-** Required Field.

**LEGAL STATUS/CASE MANAGER/PAYEE:** Make the appropriate selections for type of conservatorship and case management by marking the corresponding check boxes for these items. Enter payee and probation officer information, if applicable, in the spaces provided.

**SOURCE OF INFORMATION- Required Field.** Select from the Source of information Table below. Include the ID and Description in your documentation. If “Other” is selected, please provide information.

ID	Description	ID	Description
AB2726 Asr	AB2726 Assessor	Other	Other
ADS Prov	ADS Recovery Provider	Parent LG	Parent/Legal Guardian
Client	Client	Prev Asst	Previous Assessment
Case Mnager	Case Manager	Probation/Parole Officer	Probation/Parole Officer
Conservatr	Conservator	Soc Worker	Social Worker
Family	Family	Teacher	Teacher/School
Fos Parent	Foster Parent	Therapist	Therapist
MD	MD		

**REPORTS REVIEWED:** Enter any reports used as part of the assessment.

**REFERRAL SOURCE:** Select from the Referral Source Table Below. Include the ID and Description in your documentation. If “Other” is selected, please provide information.

ID	Description	ID	Description
1	ACL	12	Partners Program
2	CAPS	13	Primary Care Provider/FQHC
3	CWS	14	Probation
4	Case Management Program	15	SARB
5	Crisis Action and Connection (CAC)	16	School
6	ESU	17	Self/Family
7	FFS Hospital	18	Substance Abuse Treatment OP/TRC
8	FFS Provider	19	Substance Abuse Treatment Residential
9	Group Home/Residential Tx Facility	20	TBS
10	OP Clinic/School Based	21	Other
11	PEI Program		

**PRESENTING PROBLEMS/NEEDS:** Write in the area provided, using the help text as a guide.

**PAST PSYCHIATRIC HISTORY:** Write in the area provided, using the help text as a guide.

**FAMILY HISTORY:**

LIVING ARRANGEMENT:

Select from the Living Arrangement Table below. Include the ID and Description in your documentation. If “Other” is selected, please provide information.

<b>Living Arrangement</b>
---------------------------

A-House or Apartment B-House or Apt with Support C-House or Apt with Daily Supervision Independent Living Facility D-Other Supported Housing Program E-Board & Care – Adult F-Residential Tx/Crisis Ctr – Adult	G-Substance Abuse Residential Rehab Ctr H-Homeless/In Shelter I-MH Rehab Ctr (Adult Locked) J-SNF/ICF/IMD K-Inpatient Psych Hospital L-State Hospital M-Correctional Facility	O-Other R-Foster Home-Child S-Group Home-Child (Level 1-12) T-Residential Tx Ctr-Child (Level 13-14) U-Unknown V-Comm Tx Facility (Child Locked) W- Children’s Shelter
---	--	--

Those living in the home with client: List the names and relationship to client, and other pertinent information, in the space provided.

Have any relatives ever been impacted by the following: For each listed condition, enter information from the family members table, if applicable, in the spaces provided. Leave blank if there are none:

ID	DESCRIPTION	ID	DESCRIPTION	ID	DESCRIPTION
<b>Aunt Bio</b>	Aunt – Biological	<b>Fath InLaw</b>	Father – In-Law	<b>Niece Bio</b>	Niece – Biological
<b>Aunt NoBio</b>	Aunt – Non-biological	<b>Fath Step</b>	Father-Step	<b>Niece NBio</b>	Niece – Non-biological
<b>Bro Adop</b>	Brother – Adopted	<b>Gdaug Bio</b>	Granddaughter – Biological	<b>Other</b>	Other
<b>Bro Bio</b>	Brother – Biological	<b>GDaug NBio</b>	Granddaughter – Non-biological	<b>Sis Adop</b>	Sister-Adopted
<b>Bro Foster</b>	Brother – Foster	<b>GrFa Bio</b>	Grandfather – Biological	<b>Sis Bio</b>	Sister-Biological
<b>Bro InLaw</b>	Brother – In-Law	<b>GrFa NBio</b>	Grandfather – Non-biological	<b>Sis Foster</b>	Sister – Foster
<b>Bro Step</b>	Brother – Step	<b>GrMo Bio</b>	Grandmother – Biological	<b>Sis InLaw</b>	Sister – In-Law
<b>Cous Bio</b>	Cousin – Biological	<b>GrMo NBio</b>	Grandmother – Non-biological	<b>Sis Step</b>	Sister – Step
<b>Cous Nbio</b>	Cousin – Non-biological	<b>GrSon Bio</b>	Grandson – Biological	<b>Son Adopt</b>	Son-Adopted
<b>Daug Adopt</b>	Daughter – Adopted	<b>GrSon NBio</b>	Grandson – Non-biological	<b>Son Bio</b>	Son – Biological
<b>Daug Bio</b>	Daughter – Biological	<b>Husband</b>	Husband	<b>Son Foster</b>	Son – Foster
<b>Daug Foster</b>	Daughter – Foster	<b>Mother Ado</b>	Mother – Adopted	<b>Son in Law</b>	Son – In-Law
<b>Daug InLaw</b>	Daughter – In-Law	<b>Mother Bio</b>	Mother – Biological	<b>Son Step</b>	Son – Step
<b>Daug Step</b>	Daughter – Step	<b>Mother Fos</b>	Mother – Foster	<b>Signif Oth</b>	Significant Other
<b>Dom Partner</b>	Domestic Partner	<b>Mo In Law</b>	Mother – In-Law	<b>Sig Supp</b>	Significant Support Person
<b>Fath Adop</b>	Father – Adopted	<b>Mo Step</b>	Mother – Step	<b>Uncle Bio</b>	Uncle - Biological
<b>Fath Bio</b>	Father – Biological	<b>Neph Bio</b>	Nephew – Biological	<b>Uncl NBio</b>	Uncle – Non-biological
<b>Fath Fost</b>	Father – Foster	<b>Neph NBio</b>	Nephew – Non-biological	<b>Wife</b>	Wife

Include relevant family information impacting the client: (Further explain family member’s involvement in substance use)

List all family strengths that will help client succeed.

**EDUCATION:** Check the appropriate boxes as indicated. Describe any items as appropriate. Describe Educational Strengths.

**EMPLOYMENT:** Check the appropriate boxes as indicated. Describe any items as appropriate. Enter last day worked, if appropriate. Describe Employment Strengths.

**SOCIAL CONCERNS:** Check all boxes as applicable. Give explanations for all “yes” answers in the text box below. When answering “yes,” this will indicate a social concern that the client is experiencing; i.e. Client frequently spends time with peers that engage in substance use behaviors. When the answer is “no,” there is no need to complete the text box unless one chooses to do so. Note: Justice System is a **REQUIRED** prompt.

**MILITARY HISTORY:** Enter requested information in the spaces provided.

**CULTURAL INFORMATION:** Write in the area provided.

**SEXUAL ORIENTATION:** Select all that apply. (*Help Text see Appendix A, page 5*). Complete clinical considerations in text box as indicated.

**GENDER IDENTITY:** Select from choices available. (*Help Text see Appendix A, page 5*). Complete clinical considerations in text box as indicated.

**HISTORY OF SELF-INJURY/SUICIDE/VIOLENCE:** Check the boxes appropriately. A Yes or Refuse/Cannot Assess response requires detailed documentation.

**SUBSTANCE USE INFORMATION:** Check the boxes appropriately and address all fields for tobacco use. If History of Substance Use marked Yes, specify substances used, this includes answering ALL prompts.

History of substance use treatment: Document as appropriate

Does client have a co-occurring disorder (COD): Check appropriate box

Quadrant: Indicate mental health and substance abuse level of need.

Stages of Change: Substance Abuse Recovery. Indicate client’s current Stage of Change.

Describe how substance use impacts current level of functioning if appropriate.

Recommendation for substance use treatment. Check box as appropriate. Explain if Yes is checked.

Gambling: Answer the questions as appropriate. If Yes answer, describe.

### **HIGH RISK ASSESSMENT**

**ASSESSMENT OF IMMEDIATE RISK FACTORS.** Answer all questions with appropriate check box. A Yes or refuse/Cannot Assess response requires detailed documentation.

**PROTECTIVE FACTORS.** Document as appropriate.

**SELF INJURY/SUICIDE/VIOLENCE MANAGEMENT PLAN:** Document as appropriate. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session.

**TARASOFF ASSESSMENT.** Answer all questions with appropriate check box. Document details as necessary for any “yes” answers.

**CURRENT DOMESTIC VIOLENCE** Answer all questions with appropriate check box. If Yes, documentation and child/adult protective question is mandatory. Describe the situation.

## **MEDICAL TAB**

### **ALLERGIES AND ADVERSE MEDICATION REACTIONS.**

Answer appropriately. If “yes” provide detailed information in text box. Share any allergy information with medical staff.

For rest of the Medical Tab, select appropriate check boxes. If there are any Yes answers, give explanations as appropriate.

**FUNCTIONAL ASSESSMENT** This is not used by all programs. This is completed for clients that are 65 years or older. Complete as appropriate.

### **MENTAL STATUS EXAM**

Complete, selecting check boxes as appropriate. Complete the Hallucinations questions at the end of this tab, describing any Yes answers.

**CASE MANAGEMENT** This is not used by all programs. Typically used for Case Management Programs. Complete as appropriate.

## **BHA SIGNATURE PAGE**

**CLINICAL FORMULATION:** Document justification and medical necessity in the space provided, using the form’s Help Text as a guide.

MEDICAL NECESSITY MET: Check the appropriate boxes, as indicated.

**CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE:** Provide the dates and check each item as completed.

**Signatures:** The clinician completing the form will sign his/her name with credential on the signature line, and print their name on the second line. Date and Anasazi Staff ID number are documented at the appropriate prompts.

When a clinician needs a co-signature, a qualified clinician will sign, print name, date and enter Anasazi Staff ID as indicated. Refer to Scope of Practice to identify who needs a co-signature.

## Appendix A:

### *Sexual orientation:*

*The type of sexual, romantic, and/or physical attraction someone feels towards others. Who a person is primarily attracted to physically, romantically, and/or emotionally, for example, males, females, both, neither; enduring emotional, romantic or sexual attraction to other people. One's sexual behavior affects the choices one makes in responding to sexual orientation. It is the attraction that shapes one's orientation.)*

*Another sexual orientation: not attracted to either female or male; can refer to a person who is asexual and does not have a sexual attraction or desire to any group of people. Asexuality is not the same as celibacy.*

*Bisexual: is romantic attraction, sexual attraction, or sexual behavior toward both males and females or romantic or sexual attraction to people of any sex of gender identity. A person who is "bi" may not have had an equal amount of sexual experiences with people of the same sex*

*Decline to state: client may be unsure or unwilling to disclose*

*Gay: emotionally, romantically, and/or physically attracted to people of the same sex; although it can be used for any sex (e.g., gay man, gay woman, gay person), "lesbian" is sometimes the preferred term for women who are attracted to women; a gay person may not have had any sexual experience; it is the attraction that shapes sexual orientation.*

*Heterosexual/straight: emotionally, romantically, and/or physically attracted to people of the opposite gender.*

*Lesbian: a woman who is emotionally, romantically, and/or physically attracted to other women; women may also use the term gay to describe themselves; a gay or lesbian woman may not have had any sexual experience.*

*Queer: Think of queer as an umbrella term. It includes anyone who: a) wants to identify as queer and b) who feels somehow outside the societal norm in regards to gender or sexuality. This therefore, could include the person who highly values queer theory concepts and would rather not identify with any particular label, the gender fluid bisexual, the gender fluid heterosexual, the questioning LGBT person, and the person who just doesn't feel like they quite fit in to societal norms and wants to bond with a community over that. Originally pejorative for gay; this term has been reclaimed by some gay men, lesbians, bisexuals and transgendered persons as a self-affirming umbrella term. It is a fluid label as opposed to a solid label.*

*Questioning/Unsure: exploring sexual orientation, gender identity, gender expression)*

### *Gender Identity:*

*The sense of "being" male, female, genderqueer, agender, etc. For some people, gender identity is in accord with physical anatomy. For transgender people, gender identity may differ from physical anatomy or expected societal roles. It is important to note that gender identity, biological sex, and sexual orientation are separate and that you cannot assume how someone identifies in one category based on they identify in another category.)*

*Another gender identity: some of both male and female or neither; refer to genderqueer for more information*

*Genderqueer: Genderqueer is most commonly used to describe a person who feels that his/her gender identity does not fit into the socially constructed "norms" associated with his/her biological sex. Genderqueer identities can include one or more of the following: both man and woman, neither man or woman [genderless], moving between genders [gender fluid], third gender or other gender, those who do not or cannot place a name to their gender, and having an overlap of, or blurred lines between gender identity and sexual orientation.*

*Questioning/unsure: exploring sexual orientation, gender identity, gender expression*

*Transgender: It is frequently used as an umbrella term to refer to people who do not identify with their assigned gender at birth. This includes transsexuals, cross-dressers, genderqueer, drag kings, two spirit people and others. Some transgender people feel like they exist not within one of the two standard gender categories, but rather somewhere in between, beyond, or outside of those two genders.*

**County of San Diego Mental Health Services**  
**BEHAVIORAL HEALTH ASSESSMENT – ADULT WALK IN CLINIC**

\*Client Name:

\*Case #:

\*Assessment Date

\*Program Name:

**BHA ADULT TAB**

**LEGAL STATUS/CASE MANAGER/PAYEE**

Conservator:             None             LPS             Probate             Temporary

Case Manager:  None             SBCM             FSP             Institutional  
 Regional Center             Other

Payee:

Probation/Parole Officer:

**\*SOURCE OF INFORMATION:** *Select from Source of Information table listed on the Instructions Sheet*

\*Referral Source:

If other, specify:

**PRESENTING PROBLEMS/NEEDS:** *(Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and history of present illness. Summary of client's request for services including client's most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors; include experiences of stigma and prejudice, if any)*

**PAST PSYCHIATRIC HISTORY:** *(History of symptoms and/or mental health treatment. Describe in chronological order - where, when, and length of time. Include dates and providers related to any prior psychiatric treatment, history, traumatic and/or significant events, and/or trauma related to treatment. Include the most recent periods of stability and the characteristics of those periods)*

**FAMILY HISTORY:**

Living Arrangement: *Select from Living Arrangement table listed in the Instructions Sheet*

Those living in the home with client:

**SOCIAL CONCERNS:**

Family/community support system             No     Yes     Refuse/Cannot Assess  
Justice system             No     Yes     Refuse/Cannot Assess

A YES response to any of the above requires detailed documentation:

**SEXUAL ORIENTATION:** *(Help Text see Appendix A)*

Select all that apply:

Heterosexual/Straight             Bisexual             Lesbian             Gay             Queer  
 Another sexual orientation             Questioning/Unsure             Decline to state

**GENDER IDENTITY:** *(Help Text see Appendix A)*

Assigned at birth (Select one):  Male  Female  Decline to state

Current Gender (Select all that apply):

Male  Female  Transgender  Genderqueer  
 Another gender identity  Questioning/Unsure  Decline to state

Clinical Considerations:

**HISTORY OF SELF-INJURY/SUICIDE/VIOLENCE:**

History of self-injury (cutting, burning)  No  Yes  Refuse/Cannot Assess  
 History of suicide attempt/s:  No  Yes  Refuse/Cannot Assess  
 History of violence toward another:  No  Yes  Refuse/Cannot Assess  
 History of significant property destruction:  No  Yes  Refuse/Cannot Assess  
 History of domestic violence:  No  Yes  Refuse/Cannot Assess  
 History of abuse:  No  Yes  Refuse/Cannot Assess  
 Abuse reported:  N/A  No  Yes  Refuse/Cannot Assess  
 Experience of traumatic event/s:  No  Yes  Refuse/Cannot Assess

A YES or refuse/cannot assess response to any of the above requires detailed documentation:

**SUBSTANCE USE INFORMATION:**

History of Substance Use?  No  Yes  Refuse/Cannot Assess

(if yes, specify substances used)

Name of Drug	Priority	Method of Administration	Age 1 <sup>st</sup> used	Freq- uency of Use	Days of use in last 30 days	Date of last use	Amount of last use	Amount used on a typical Day	Largest Amount Used in One Day

History of substance use treatment: *(Types of treatment, level of care, length of treatment, etc.)*

**HIGH RISK ASSESSMENT TAB**

**ASSESSMENT OF IMMEDIATE RISK FACTORS:** Any “yes” response triggers enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session.

Direct (past 2 weeks) discharge from 24 hour program *due to suicidal or homicidal crisis* (hospital, IMD, START, residential treatment, etc.) No Yes Refuse/Cannot Assess

Current serious thoughts/impulses of hurting/killing self or others: No Yes Refuse/Cannot Assess  
*Note if access to fire arms (guns) or other lethal means:*

Pre-death behavior/committed to dying (e.g. giving away possessions) and/or current hopelessness/sees no options No Yes Refuse/Cannot Assess

Preoccupied with incapacitating or life threatening illness and/or chronic intractable pain and/or catastrophic social loss No Yes Refuse/Cannot Assess

Current command hallucinations, intense paranoid delusions and/or command override symptoms (belief that others control thoughts/actions) No Yes Refuse/Cannot Assess

Current behavioral dyscontrol with intense anger/humiliation, recklessness, risk taking, self-injury and/or physical aggression and violence No Yes Refuse/Cannot Assess

**Additional Youth Risk Factors:**

Current extreme social alienation, isolation and/or victim of bullying No Yes Refuse/Cannot Assess

A YES or REFUSE/CANNOT Assess response to any of the above requires detailed documentation:

**PROTECTIVE FACTORS:** (strong religious, cultural, or inherent values against harming self/others, strong social support system, positive planning for future, engagement in treatment, valued care giving role (people or pets) and strong attachment/responsibility to others.)

**SELF-INJURY/SUICIDE/VIOLENCE MANAGEMENT PLAN:** (Document enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session.)

**TARASOFF ASSESSMENT:**

**Current Violent Impulses and/or Homicidal ideation toward a reasonably identified victim?** No Yes Refuse/Cannot Assess

Tarasoff Warning Indicated? No Yes

*If yes, include victim(s) name and contact information (Tarasoff Warning Details):*

Reported To:                      Date:

**CURRENT DOMESTIC VIOLENCE?**                      No   Yes   Refuse/Cannot Assess

*If yes, detailed documentation and child/adult protective services question mandatory. Describe situation:*

Child/Adult Protective Services Notification Indicated?                       No   Yes

Reported To:                      Date:

**MEDICAL TAB**

**ALLERGIES AND ADVERSE MEDICATION REACTIONS:**   No   Yes   Unknown/Not Reported

If Yes, specify:

(Share this allergy information with your medical staff.)

Medications are recorded in the Doctors Home Page (DHP)

Does client have a Primary Care Physician?                      No   Yes    Unknown

If No, has client been advised to seek primary care?                      No   Yes

Primary Care Physician:

Phone Number:

Seen within the last:    6 months    12 months    Other:

Hospital of choice (physical health):

Have you ever been hospitalized for any major illness?                      No   Yes    Refuse/Cannot Assess

Have you ever had an operation?                      No   Yes    Refuse/Cannot Assess

Have you had any complications from a childhood disease?                      No   Yes    Refuse/Cannot Assess

Has sleep been a problem?                      No   Yes    Refuse/Cannot Assess

Has there been a change in appetite?                      No   Yes    Refuse/Cannot Assess

A YES or REFUSE/CANNOT assess response to any of the above requires detailed documentation:

Physical Health issues:                      None at this time   Yes

If Yes, specify:

Is condition followed by Primary Care Physician?   No                      Yes   N/A

Physical health problems affecting mental health functioning:

Head injuries:   No   Yes

If Yes, specify:

## MENTAL STATUS EXAM TAB

Unable to assess at this time.

### Level of Consciousness

Alert       Lethargic       Stuporous

### Orientation

Person    Place    Day    Month    Year    Current Situation  
 All Normal    None

### Appearance

Good Hygiene       Poor Hygiene       Malodorous       Disheveled  
 Reddened Eyes       Normal Weight       Overweight       Underweight

### Speech

Normal       Slurred       Loud       Soft       Pressured       Slow       Mute

### Thought Process

Coherent       Tangential       Circumstantial       Incoherent       Loose Association

### Behavior

Cooperative    Evasive    Uncooperative    Threatening    Agitated    Combative

### Affect

Appropriate    Restricted    Blunted       Flat       Labile    Other

### Intellect

Average       Below Average       Above Average       Poor Vocabulary  
 Poor Abstraction       Paucity of Knowledge       Unable to Rate

### Mood

Euthymic       Elevated       Euphoric       Irritable       Depressed       Anxious

### Memory

Normal       Poor Recent       Poor Remote       Inability to Concentrate  
 Confabulation       Amnesia

### Motor

Age Appropriate/Normal       Slowed/Decreased       Psychomotor Retardation  
 Hyperactive       Agitated       Tremors       Tics       Repetitive Motions

### Judgment

Age Appropriate/Normal       Poor       Unrealistic  
 Fair       Limited       Unable to Rate

### Insight

Age Appropriate/Normal       Poor       Fair       Limited       Adequate       Marginal

### Command Hallucinations

No    Yes, specify:

### Auditory Hallucinations

No    Yes, specify:

### Visual Hallucinations

No    Yes, specify:

### Tactile Hallucinations

No    Yes, specify:

### Olfactory Hallucinations

No    Yes, specify:

### Delusions

No    Yes, specify:

Other observations/comments when applicable :

**DIAGNOSTIC REVIEW TAB**

**DIAGNOSIS** If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Behavioral Health Assessment.

**BHA SIGNATURE PAGE TAB**

**CLINICAL FORMULATION:** (Justification for diagnosis and medical necessity. Summarize and integrate all information gathered from other sources to render clinical judgment regarding intensity, length of treatment and recommendations for service. Clearly state those emotional or behavioral symptoms that interfere with normal functioning. Include evaluation of client’s ability and willingness to solve the presenting problems, address both mental health and substance issues from an integrated perspective.)

**MEDICAL NECESSITY MET:**  No  Yes

When “No,” note date NOA-A issued [Medi-Cal clients only]:

**CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE?**  Yes Date:

Local mental health program shall inform Clients receiving mental health services, including parents or guardians of children / adolescents, verbally or in writing that:

- Acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services;
- They retain the right to access other Medi-Cal or Short Doyle/Medi-Cal reimbursable services and have the right to request a change of provider, staff person, therapist, and/or case manager.
- Guide to Medi-Cal Mental Health Services was explained and offered on:**
- Grievance and Appeal Process explained and Brochure with form fill and envelope offered on:**
- Provider List explained and offered on:**
- Mental Health Plan’s Notice of Privacy Practices (NPP) was offered on:**
- Language/Interpretation services availability reviewed and offered when applicable on:**
- Advanced Directive brochure was offered on:**
- Voter registration material was offered to client at intake or change of address:**

Signature of Clinician Requiring Co-signature:

\_\_\_\_\_  
Signature

Date:

Printed Name

Cerner ID number:

\*Signature of Clinician Completing/Accepting the Assessment:

---

Signature

Date:

Printed Name

Cerner ID number:

## Appendix A:

### *Sexual orientation:*

*The type of sexual, romantic, and/or physical attraction someone feels towards others. Who a person is primarily attracted to physically, romantically, and/or emotionally, for example, males, females, both, neither; enduring emotional, romantic or sexual attraction to other people. One's sexual behavior affects the choices one makes in responding to sexual orientation. It is the attraction that shapes one's orientation.)*

*Another sexual orientation: not attracted to either female or male; can refer to a person who is asexual and does not have a sexual attraction or desire to any group of people. Asexuality is not the same as celibacy.*

*Bisexual: is romantic attraction, sexual attraction, or sexual behavior toward both males and females or romantic or sexual attraction to people of any sex of gender identity. A person who is "bi" may not have had an equal amount of sexual experiences with people of the same sex*

*Decline to state: client may be unsure or unwilling to disclose*

*Gay: emotionally, romantically, and/or physically attracted to people of the same sex; although it can be used for any sex (e.g., gay man, gay woman, gay person), "lesbian" is sometimes the preferred term for women who are attracted to women; a gay person may not have had any sexual experience; it is the attraction that shapes sexual orientation.*

*Heterosexual/straight: emotionally, romantically, and/or physically attracted to people of the opposite gender.*

*Lesbian: a woman who is emotionally, romantically, and/or physically attracted to other women; women may also use the term gay to describe themselves; a gay or lesbian woman may not have had any sexual experience.*

*Queer: Think of queer as an umbrella term. It includes anyone who: a) wants to identify as queer and b) who feels somehow outside the societal norm in regards to gender or sexuality. This therefore, could include the person who highly values queer theory concepts and would rather not identify with any particular label, the gender fluid bisexual, the gender fluid heterosexual, the questioning LGBT person, and the person who just doesn't feel like they quite fit in to societal norms and wants to bond with a community over that. Originally pejorative for gay; this term has been reclaimed by some gay men, lesbians, bisexuals and transgendered persons as a self-affirming umbrella term. It is a fluid label as opposed to a solid label.*

*Questioning/Unsure: exploring sexual orientation, gender identity, gender expression)*

### *Gender Identity:*

*The sense of "being" male, female, genderqueer, agender, etc. For some people, gender identity is in accord with physical anatomy. For transgender people, gender identity may differ from physical anatomy or expected societal roles. It is important to note that gender identity, biological sex, and sexual orientation are separate and that you cannot assume how someone identifies in one category based on they identify in another category.)*

*Another gender identity: some of both male and female or neither; refer to genderqueer for more information*

*Genderqueer: Genderqueer is most commonly used to describe a person who feels that his/her gender identity does not fit into the socially constructed "norms" associated with his/her biological sex. Genderqueer identities can include one or more of the following: both man and woman, neither man or woman [genderless], moving between genders [gender fluid], third gender or other gender, those who do not or cannot place a name to their gender, and having an overlap of, or blurred lines between gender identity and sexual orientation.*

*Questioning/unsure: exploring sexual orientation, gender identity, gender expression*

*Transgender: It is frequently used as an umbrella term to refer to people who do not identify with their assigned gender at birth. This includes transsexuals, cross-dressers, genderqueer, drag kings, two spirit people and others. Some transgender people feel like they exist not within one of the two standard gender categories, but rather somewhere in between, beyond, or outside of those two genders.*

**San Diego County Mental Health Services  
BEHAVIORAL HEALTH ASSESSMENT – CHILDREN**

**\*Client Name:**                      **\*Case #:**

**\*Assessment Date**                      **\*Program Name:**

**BHA CHILDREN TAB**

**PATHWAYS TO WELL-BEING/KTA**

Client is involved with Child Welfare Services  No  Yes

May call CWS at 858-694-5191 to obtain name of current worker.

CWS PSW:                      PSW Phone:                      PSW Email:

**1. Legal Status for CWS client:**

- VS – Voluntary Services (*CWS has not filed a petition due to intent to divert from dependency by providing services; Court does not have jurisdiction.*)
- Pre-Adjudication (*CWS has filed a petition in Court; child may be with parents or may have been removed and dependency has not yet been established.*)
- FM – Family Maintenance (*Court has jurisdiction; dependent placed at home with parent.*)
- FR – Family Reunification (*Court has jurisdiction; dependent in out of home placement.*)
- EFC – Extended Foster Care
- PP – Permanent Plan: Court has jurisdiction – specify:
  - i.  APPLA: another planned permanent living arrangement
  - ii.  Legal Guardianship is pending; once finalized, dependency ends
  - iii.  Adoption is pending; once finalized, dependency ends

**2. CWS Child Living Arrangement:**

- Parents
- Relative
- Non-Relative Extended Family Member (NREFM)
- Licensed Foster Home
- San Pasqual Academy
- Supervised Independent Living Placement (SILP)
- Foster Family Agency Home (FFA)
- Licensed Group Home (LGH)
- Residential Treatment Center (RTC) [LGH with a Mental Health Contract]

FFA Name:

LGH Name:

RTC Name:                       RTC Level 12       RTC Level 14

3. Petition True Finding (may be multiple): *(Based on Welfare and Institution Code, Section 300, as adjudicated by Juvenile Court)*

- Physical Abuse
- Neglect (general or severe)
- Emotional Abuse
- Sexual Abuse
- Severe Physical Abuse of child under the age of five
- Death of another child (caused by parent)
- No parent or guardian
- Freed for adoption and adoption petition not granted
- Cruelty
- Child/client at risk due to abuse of sibling

4. Katie A. Class or Sub-Class status (select one based on completed Katie A. Eligibility form):  
*(Not member of class or Sub-Class; no Child Welfare Services involvement; CWS section not applicable. Eligibility status pending; must determine Class vs. Sub-Class status within 30 days of assignment opening.)*

- Member of Class
- Member of Sub-Class
- Not member of Class or Sub-Class
- Eligibility status pending

**OTHER AGENCY INVOLVEMENT:**  Regional Center  Probation  Other:

**\*SOURCE OF INFORMATION:** *(Select from Source of Information Table located in the Instructions sheet)*

If other, specify  
Reports Reviewed:

Referral Source: *(Select from Referral Source Table located in the Instructions sheet)*

If Other, specify:

**PRESENTING PROBLEMS/NEEDS** *(Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and history of present illness. Summary of client's request for services including client's most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors; include experiences of stigma and prejudice, if any.)*

**PAST PSYCHIATRIC HISTORY** *(Previous history of symptoms and/or mental health treatment. Describe in chronological order - where, when, and length of time. Include dates and providers related to any prior psychiatric treatment, history, traumatic and/or significant events, and/or trauma related to treatment. Include the most recent periods of stability and the characteristics of those periods.)*

**HISTORY OF EARLY INTERVENTIONS:**

- Speech-Language     Occupational     Behavioral
- Physical     Hearing     Counseling
- Parent Training     Educational     Developmental
- Psychological     Special Education

Describe:

**EDUCATION:**

- Area of Concerns:    Academic    Behavioral    Social  
No issue reported    Other:

Education (last grade completed):

Failed the following grade(s):

- Client has an active 504 Plan:     No     Yes     Refuse/Cannot Assess  
Client has an active IEP:     No     Yes     Refuse/Cannot Assess  
Special Education:     No     Yes     Refuse/Cannot Assess  
Is Client receiving mental health services through a school district?     No     Yes     Refuse/Cannot Assess

Describe:

Educational Strengths:

**EMPLOYMENT:**    Does not apply

- History of volunteer/community service:     No     Yes     Refuse/Cannot Assess  
History of work experience:     No     Yes     Refuse/Cannot Assess  
Current work experience:     No     Yes     Refuse/Cannot Assess  
Last date worked:

- Area of Concerns:    Skills Readiness    Barriers    Training    Job retention  
No issue reported/NA    Other:

Describe:

Employment Strengths:

**SOCIAL CONCERNS:**

- Peer/Social Support     No     Yes     Refuse/Cannot Assess  
Substance use by peers     No     Yes     Refuse/Cannot Assess  
Gang affiliations     No     Yes     Refuse/Cannot Assess  
Family/community support system     No     Yes     Refuse/Cannot Assess  
Religious/spirituality     No     Yes     Refuse/Cannot Assess  
\*Justice system     No     Yes     Refuse/Cannot Assess

A YES response to any of the above requires detailed documentation:

**FAMILY HISTORY:**

Living Arrangement: *Select from Living Arrangement Table listed on the Instruction Sheet.*

Those living in the home with client:

Have any relatives ever been impacted by the following:-(*Select from Relatives table listed in the Instructions Sheet. Indicate who and expand below if applicable*)

Suicidal thoughts, attempts:

Violence:

Domestic violence:

Substance abuse or addiction:

Other addictions:

Gang involvement:

Emotional/mental health issues:

Physical health conditions:

Intellectual developmental disorder:

Developmental delays:

Arrests:

Abuse:

Abuse reported:  N/A  No  Yes  Refuse/Cannot Assess

Include relevant family information impacting the client:

Family strengths:

**CULTURAL INFORMATION:** (*Considerations could include language of client/family, primary language spoken at home, religious, spiritual beliefs, family structures, customs, moral/legal systems, life-style changes, socio-economic background, ethnicity, race, immigration history/experience, age, and subculture (homelessness, gang affiliations, substance use, foster care, military background), exposure to violence, abuse and neglect, experience with racism, discrimination, and social exclusion. Describe unique cultural and linguistic needs and strengths that may impact treatment. Cultural information includes an understanding of how client's mental health is impacted. Consider using the Cultural Formulation Interview in the DSM 5 for further guidance.*)

**SEXUAL ORIENTATION:** (*Help Text see Appendix A*)

Select all that apply:

- Heterosexual/Straight  Bisexual  Lesbian  Gay  Queer  
 Another sexual orientation  Questioning/Unsure  Decline to state

**GENDER IDENTITY:** (Help Text see Appendix A)

Assigned at birth (Select one):  Male  Female  Decline to state

Current Gender (Select all that apply):

Male  Female  Transgender  Genderqueer  
 Another gender identity  Questioning/Unsure  Decline to state

Clinical Considerations:

**HISTORY OF SELF-INJURY/SUICIDE/VIOLENCE:**

History of self-injury (cutting, burning)  No  Yes  Refuse/Cannot Assess  
History of suicide attempt/s:  No  Yes  Refuse/Cannot Assess  
History of violence toward another:  No  Yes  Refuse/Cannot Assess  
History of significant property destruction:  No  Yes  Refuse/Cannot Assess  
History of domestic violence:  No  Yes  Refuse/Cannot Assess  
History of abuse:  No  Yes  Refuse/Cannot Assess  
Abuse reported:  N/A  No  Yes  Refuse/Cannot Assess  
Experience of traumatic event/s:  No  Yes  Refuse/Cannot Assess

A YES or REFUSE/CANNOT assess response to any of the above requires detailed documentation:

**SUBSTANCE USE INFORMATION:**

Have you ever used tobacco/nicotine products?  No  Yes  Refuse/Cannot Assess

At what age did you first use tobacco/nicotine products:

Smoker Status:

In the past 30 days, what tobacco product did you use most frequently?  
If other, specify:

What age did you stop using tobacco/nicotine products?

Has the client been informed of the risks? (Smoking is a serious health risk that leads to cancer, cardiovascular disease and possibility of premature death.)  No  Yes  Refuse/Cannot Assess

Have Smoking Cessation Resources been offered?  No  Yes  Refuse/Cannot Assess

**CRAFFT** (Administer measure by providing handout or reading questions verbatim, in order and without interpretation)  
Copyright held by Children’s Hospital Boston, 2001. Reproduced with permission from the Center for Adolescent Substance Abuse Research, CeASAR, Children’s Hospital Boston.  
For more information, contact [infor@CRAFFT.org](mailto:infor@CRAFFT.org) or visit [www.crafft.org](http://www.crafft.org)

HAVE YOU EVER?	Yes	No
C-Have you ever ridden in a CAR driven by someone (including yourself) who was “high” or had been using alcohol or drugs?		

R-Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?		
A-Do you ever use alcohol or drugs while you are by yourself ALONE?		
F-Do you ever FORGET things you did while using alcohol or drugs?		
F-Does your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?		
T-Have you ever gotten into TROUBLE while you were using alcohol or drugs?		

2 or more "Yes" answers suggest a significant problem.

**TOTAL:**

**Have you ever experienced (only 1-3 times) with any substances?**  No  Yes  Refuse/Cannot Assess  
 ("Yes" is only to be endorsed when client is exclusively experimenting and has not progressed to regular use or abuse of any substances.)

**Client has a parent or caregiver with a substance abuse problem?**  No  Yes  Refuse/Cannot Assess

**History of Substance Use?**  No  Yes  Refuse/Cannot Assess

(if yes, specify substances used)

Name of Drug	Priority	Method of Administration	Age 1 <sup>st</sup> used	Freq- uency of Use	Days of use in last 30 days	Date of last use	Amount of last use	Amount used on a typical Day	Largest Amount Used in One Day

History of substance use treatment: (Types of treatment, level of care, length of treatment, etc.)

Does client have a co-occurring disorder (COD):  No  Yes  Refuse/Cannot Assess

**Quadrant:**

- Q. I: Low / Low                       Q. II: High / Low  
 Q. III: Low / High                       Q. IV: High / High

**Stages of Change: Substance Abuse Recovery**

- Pre-Contemplation                       Contemplation  
 Preparation/Determination                       Action  
 Maintenance                                       Not applicable

When applicable, describe how substance use impacts current level of functioning:

Recommendation for substance use treatment: No Yes Not applicable

If Yes:

**Gambling:**

Have you ever felt the need to bet more and more money? No Yes Refuse/Cannot Assess

Have you ever had to lie to people important to you about how much you gambled? No Yes Refuse/Cannot Assess

If Yes:

**HIGH RISK ASSESSMENT TAB**

**ASSESSMENT OF IMMEDIATE RISK FACTORS:** Any “yes” response triggers enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session.

Direct (past 2 weeks) discharge from 24 hour program No Yes Refuse/Cannot Assess  
*due to suicidal or homicidal crisis* (hospital, IMD, START, residential treatment, etc.)

Current serious thoughts/impulses of hurting/killing self or others: No Yes Refuse/Cannot Assess  
*Note if access to fire arms (guns) or other lethal means:*

Pre-death behavior/committed to dying No Yes Refuse/Cannot Assess  
(e.g. giving away possessions)and/or current hopelessness/sees no options

Preoccupied with incapacitating or life threatening illness and/or chronic intractable pain and/or catastrophic social loss No Yes Refuse/Cannot Assess

Current command hallucinations, intense paranoid delusions and/or command override symptoms (belief that others control thoughts/actions) No Yes Refuse/Cannot Assess

Current behavioral dyscontrol with intense anger/humiliation, recklessness, risk taking, self-injury and/or physical aggression and violence No Yes Refuse/Cannot Assess

**Additional Youth Risk Factors:**

Current extreme social alienation, isolation and/or victim of bullying No Yes Refuse/Cannot Assess

A YES or Refuse/Cannot Assess response to any of the above requires detailed documentation:

**PROTECTIVE FACTORS:** (strong religious, cultural, or inherent values against harming self/others, strong social support system, positive planning for future, engagement in treatment, valued care giving role (people or pets) and strong attachment/responsibility to others.)

**SELF-INJURY/SUICIDE/VIOLENCE MANAGEMENT PLAN:** (Document enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session.)

**TARASOFF ASSESSMENT:**

Current Violent Impulses and/or Homicidal ideation toward a reasonably identified victim? No Yes Refuse/Cannot Assess

Tarasoff Warning Indicated? No Yes

*If yes, include victim(s) name and contact information (Tarasoff Warning Details):*

Reported To:                      Date:

**CURRENT DOMESTIC VIOLENCE?** No Yes Refuse/Cannot Assess

*If yes, detailed documentation and child/adult protective services question mandatory.*

Describe situation:

Child/Adult Protective Services Notification Indicated?  No Yes

Reported To:                      Date:

**MENTAL STATUS EXAM TAB**

Unable to assess at this time.

Level of Consciousness

Alert             Lethargic             Stuporous

Orientation

Person     Place     Day     Month     Year     Current Situation

All Normal     None

Appearance

Good Hygiene             Poor Hygiene             Malodorous             Disheveled

Reddened Eyes             Normal Weight             Overweight             Underweight

Speech

- Normal     Slurred     Loud     Soft     Pressured
- Slow     Mute

Thought Process

- Coherent     Tangential     Circumstantial     Incoherent     Loose Association

Behavior

- Cooperative     Evasive     Uncooperative     Threatening     Agitated     Combative

Affect

- Appropriate     Restricted     Blunted     Flat     Labile     Other

Intellect

- Average     Below Average     Above Average     Poor Vocabulary
- Poor Abstraction     Paucity of Knowledge     Unable to Rate

Mood

- Euthymic     Elevated     Euphoric     Irritable     Depressed     Anxious

Memory

- Normal     Poor Recent     Poor Remote     Inability to Concentrate
- Confabulation     Amnesia

Motor

- Age Appropriate/Normal     Slowed/Decreased     Psychomotor Retardation
- Hyperactive     Agitated     Tremors     Tics     Repetitive Motions

Judgment

- Age Appropriate/Normal     Poor     Unrealistic
- Fair     Limited     Unable to Rate

Insight

- Age Appropriate/Normal     Poor     Fair     Limited     Adequate     Marginal

Command Hallucinations

- No     Yes, specify:

Auditory Hallucinations

- No     Yes, specify:

Visual Hallucinations

- No     Yes, specify:

Tactile Hallucinations

- No     Yes, specify:

Olfactory Hallucinations

- No     Yes, specify:

Delusions

- No     Yes, specify:

Other observations/comments when applicable :

## **MEDICAL TAB**

### **\*ALLERGIES AND ADVERSE MEDICATION REACTIONS:**

(Share this allergy information with your medical staff.)

No  Yes  Unknown/Not Reported

If yes, specify:

Does client have a Primary Care Physician?  No  Yes  Unknown

If No, has client been advised to seek primary care?  No  Yes

Primary Care Physician:

Phone Number:

Seen within the last:  6 months  12 months  Other:

Hospital of choice (physical health):

Been seen for the following:

Date of last dental exam:

Hearing seems to be normal:  No  Yes

Hearing has been tested:  No  Yes

If Yes, when? Where? Results?

Vision seems normal:  No  Yes

Vision has been tested:  No  Yes

If Yes, when? Where? Results?

Wears glasses:  No  Yes

Physical Health issues:  None at this time  Yes

If yes, specify:

Is condition followed by Primary Care Physician?  No  Yes  N/A

Physical health problems affecting mental health functioning:

Head injuries:  No  Yes

If yes, specify:

Medical and/or adaptive devices:

**Healing and Health** (*Alternative healing practices and beliefs. Apart from mental health professionals, who or what helps client deal with disability/illness and/or to address substance use issues? Describe.*)

## **PREGNANCY/BIRTH HISTORY**

During pregnancy, did the mother:

Have any medical problems or injuries?  No  Yes  Refuse/Cannot Assess

Take any medications?  No  Yes  Refuse/Cannot Assess

Use any drugs or alcohol?  No  Yes  Refuse/Cannot Assess

Use tobacco?  No  Yes  Refuse/Cannot Assess

Was the pregnancy or delivery unusual or difficult in any way?  No  Yes  Refuse/Cannot Assess

Mother was unable to take the baby home with her when she left the hospital?  No  Yes  Refuse/Cannot Assess

Did the child have any medical problems in infancy?  No  Yes  Refuse/Cannot Assess

Baby's birth weight: \_\_\_\_ lbs \_\_\_\_ oz

A YES response to any of the above requires detailed documentation:

**DEVELOPMENTAL MILESTONES:**

Age at which child first:

- Crawled:
- Sat up alone:
- Walked alone:
- Weaned:
- Fed self:
- Bladder control:
- Bowel trained:
- First words:
- Spoke in complete sentences:

all within normal limits  unknown

Significant Developmental Information (when applicable):

**MEDICAL CHECKLIST:**

Has the child ever had any of the following:

- Speech problems  No  Yes  Refuse/Cannot Assess
- Head banging  No  Yes  Refuse/Cannot Assess
- Day time wetting  No  Yes  Refuse/Cannot Assess
- Night time wetting  No  Yes  Refuse/Cannot Assess
- Poor bowel control  No  Yes  Refuse/Cannot Assess
- Sleep problems  No  Yes  Refuse/Cannot Assess
- Eating problems  No  Yes  Refuse/Cannot Assess
- More interested in things than people  No  Yes  Refuse/Cannot Assess
- Ear infections  No  Yes  Refuse/Cannot Assess
- High fevers  No  Yes  Refuse/Cannot Assess
- TB  No  Yes  Refuse/Cannot Assess
- Seizures or loss of consciousness  No  Yes  Refuse/Cannot Assess
- Medical hospitalizations  No  Yes  Refuse/Cannot Assess
- Operations  No  Yes  Refuse/Cannot Assess

Serious illness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess
Child menstruating	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess
Pregnancies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess
Venereal diseases	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess
Do you know child's HIV status	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess

A YES response to any of the above requires detailed documentation:

**BHA SIGNATURE PAGE TAB**

**CLINICAL FORMULATION:** *(Justification for diagnosis and medical necessity. Summarize and integrate all information gathered from other sources to render clinical judgments regarding intensity, length of treatment and recommendations for services. Clearly state those emotional or behavioral symptoms that interfere with normal functioning. Include evaluation of client's strengths, ability and willingness to solve the presenting problems, address both mental health and substance issues from an integrated perspective.)*

**MEDICAL NECESSITY MET:**     No     Yes

When "No," note date NOA-A issued [Medi-Cal clients only]:

**CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE?**     Yes    Date: \_\_\_\_\_

Local mental health program shall inform Clients receiving mental health services, including parents or guardians of children / adolescents, verbally or in writing that:

- Acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services;
- They retain the right to access other Medi-Cal or Short Doyle/Medi-Cal reimbursable services and have the right to request a change of provider, staff person, therapist, and/or case manager.
- Guide to Medi-Cal Mental Health Services was explained and offered on:**
- Grievance and Appeal Process explained and Brochure with form fill and envelope offered on:**
- Provider List explained and offered on:**
- Mental Health Plan's Notice of Privacy Practices (NPP) was offered on:**
- Language/Interpretation services availability reviewed and offered when applicable on:**
- Advanced Directive brochure was offered on:**
- Voter registration material offered to client at intake or change of address:**

**Signature of Clinician Requiring Co-signature:**

\_\_\_\_\_  
Signature

Date:

Printed Name

Cerner ID number:

**\*Signature of Clinician Completing/Accepting the Assessment:**

\_\_\_\_\_  
Signature

Date:

Printed Name

Cerner ID number:

## Appendix A:

*Sexual Orientation: The type of sexual, romantic, and/or physical attraction someone feels towards others. Who a person is primarily attracted to physically, romantically, and/or emotionally, for example, males, females, both, neither; enduring emotional, romantic or sexual attraction to other people. One's sexual behavior affects the choices one makes in responding to sexual orientation. It is the attraction that shapes one's orientation.*

*Another sexual orientation- not attracted to either female or male; can refer to a person who is asexual and does not have a sexual attraction or desire to any group of people. Asexuality is not the same as celibacy.*

*Bisexual-is romantic attraction, sexual attraction, or sexual behavior toward both males and females or romantic or sexual attraction to people of any sex or gender identity. A person who is "bi" may not have had an equal amount of sexual experiences with people of the same sex*

*Decline to state: client may be unsure or unwilling to disclose.*

*Gay- emotionally, romantically, and/or physically attracted to people of the same sex; although it can be used for any sex (e.g., gay man, gay woman, gay person), "lesbian" is sometimes the preferred term for women who are attracted to women; a gay person may not have had any sexual experience; it is the attraction that shapes sexual orientation.*

*Heterosexual/straight- emotionally, romantically, and/or physically attracted to people of the opposite gender.*

*Lesbian- a woman who is emotionally, romantically, and/or physically attracted to other women; women may also use the term gay to describe themselves; a gay or lesbian woman may not have had any sexual experience.*

*Queer- Think of queer as an umbrella term. It includes anyone who: a) wants to identify as queer and b) who feels somehow outside the societal norm in regards to gender or sexuality. This therefore, could include the person who highly values queer theory concepts and would rather not identify with any particular label, the gender fluid bisexual, the gender fluid heterosexual, the questioning LGBT person, and the person who just doesn't feel like they quite fit in to societal norms and wants to bond with a community over that. Originally pejorative for gay; this term has been reclaimed by some gay men, lesbians, bisexuals and transgendered persons as a self-affirming umbrella term. It is a fluid label as opposed to a solid label.*

*Questioning/Unsure-exploring sexual orientation, gender identity, gender expression.*

*Gender Identity: The sense of "being" male, female, genderqueer, agender, etc. For some people, gender identity is in accord with physical anatomy. For transgender people, gender identity may differ from physical anatomy or expected societal roles. It is important to note that gender identity, biological sex, and sexual orientation are separate and that you cannot assume how someone identifies in one category based on how they identify in another category.*

*Another gender identity: some of both male and female or neither; refer to genderqueer for more information.*

*Genderqueer: Genderqueer is most commonly used to describe a person who feels that his/her gender identity does not fit into the socially constructed "norms" associated with his/her biological sex. Genderqueer identities can include one or more of the following: both man and woman, neither man or woman [genderless], moving between genders [gender fluid], third gender or other gender, those who do not or cannot place a name to their gender, and having an overlap of, or blurred lines between gender identity and sexual orientation.*

*Questioning/unsure: exploring sexual orientation, gender identity, gender expression.*

*Transgender: It is frequently used as an umbrella term to refer to people who do not identify with their assigned gender at birth. This includes transsexuals, cross-dressers, genderqueer, drag kings, two spirit people and others. Some transgender people feel like they exist not within one of the two standard gender categories, but rather somewhere in between, beyond, or outside of those two genders.*

**San Diego County Mental Health Services  
BEHAVIORAL HEALTH ASSESSMENT - CHILDREN  
Instructions**

**CLIENT NAME:** Required Field

**CASE #-** Required Field.

**ASSESSMENT DATE –** Required Field.

**PROGRAM NAME-** Required Field.

**PATHWAYS TO WELL-BEING/KTA**

Client is involved with Child Welfare Services (CWS): When this box is checked, this part of the BHA must be completed.

CWS PSW – **Required Field** : Enter PSW’s Name

PSW Phone: Enter PSW’s phone number

PSW Email: Enter PSW’s email

1. Legal Status for CWS client. Select appropriate status from choices.  
PP – Permanent Plan. Select either i., ii., or iii. as appropriate.
2. CWS Child Living Arrangement. Select living status from choices.  
Residential Treatment Center (RTC) [LGH with a Mental health Contract]. Enter name of facility.  
indicate either Level 12 or Level 14.

Petition True Finding based on Welfare and Institution Code, Section 300, as adjudicated by Juvenile Court. Select the appropriate findings from the choices. (these may be multiple selections).

Katie A. Class or Sub-Class status. Select one from choices, based on completed Katie A. Eligibility form.

**OTHER AGENCY INVOLVEMENT:** Select from choices. If “Other”, document explanation.

**SOURCE OF INFORMATION- Required Field.** Select from the Source of information Table below. Include the ID and Description in your documentation. If “Other” is selected, please provide information.

ID	Description	ID	Description
AB	AB2726 Assessor	OTH	Other
ADS	ADS Recovery Provider	PAR	Parent/Legal Guardian
CLT	Client	PRE	Previous Assessment
CM	Case Manager	PRO	Probation/Parole Officer
CON	Conservator	SOC	Social Worker
FAM	Family	TEA	Teacher/School
FOS	Foster Parent	THER	Therapist
MD	MD		

**Reports Reviewed:** Enter any reports used as part of the assessment.

**Referral Source:** Select from the Referral Source Table Below. Include the ID and Description in your documentation. If “Other” is selected, please provide information.

ID	Description	ID	Description
1	ACL	12	Partners Program
2	CAPS	13	Primary Care Provider/FQHC
3	CWS	14	Probation
4	Case Management Program	15	SARB
5	Crisis Action and Connection (CAC)	16	School
6	ESU	17	Self/Family
7	FFS Hospital	18	Substance Abuse Treatment OP/TRC
8	FFS Provider	19	Substance Abuse Treatment Residential

<b>9</b>	Group Home/Residential Tx Facility	<b>20</b>	TBS
<b>10</b>	OP Clinic/School Based	<b>21</b>	Other
<b>11</b>	PEI Program		

**PRESENTING PROBLEMS/NEEDS:** Write in the area provided, using the help text as a guide.

**PAST PSYCHIATRIC HISTORY:** Write in the area provided, using the help text as a guide.

**HISTORY OF EARLY INTERVENTION:** Check the appropriate boxes as indicated. Describe results in the space provided.

**EDUCATION:** Check the appropriate boxes as indicated. Describe any items as appropriate. Describe Educational Strengths.

**EMPLOYMENT:** Check the appropriate boxes as indicated. Describe any items as appropriate. Enter last day worked, if appropriate. Describe Employment Strengths.

**SOCIAL CONCERNS:** Check all boxes as applicable. Give explanations for all “yes” answers in the text box below. When answering “yes,” this will indicate a social concern that the client is experiencing; i.e. Client frequently spends time with peers that engage in substance use behaviors. When the answer is “no,” there is no need to complete the text box unless one chooses to do so. Note: Justice System is a **REQUIRED** prompt.

**FAMILY HISTORY:**

**LIVING ARRANGEMENT:**

Select from the Living Arrangement Table below. Include the ID and Description in your documentation. If “Other” is selected, please provide information.

<b>Living Arrangement</b>		
A-House or Apartment	G-Substance Abuse Residential Rehab Ctr	O-Other
B-House or Apt with Support	H-Homeless/In Shelter	R-Foster Home-Child
C-House or Apt with Daily Supervision Independent Living Facility	I-MH Rehab Ctr (Adult Locked)	S-Group Home-Child (Level 1-12)
D-Other Supported Housing Program	J-SNF/ICF/IMD	T-Residential Tx Ctr-Child (Level 13-14)
E-Board & Care – Adult	K-Inpatient Psych Hospital	U-Unknown
F-Residential Tx/Crisis Ctr – Adult	L-State Hospital	V-Comm Tx Facility (Child Locked)
	M-Correctional Facility	W- Children’s Shelter

**THOSE LIVING IN THE HOME WITH THE CLIENT:** List the names and relationship to client, and other pertinent information, in the space provided

**HAVE ANY RELATIVES EVER HAD ANY OF THE FOLLOWING CONDITIONS:** For each listed condition, enter information from the family members table, if applicable, in the spaces provided. Expand below when applicable. Leave blank if there are none:

<b>ID</b>	<b>DESCRIPTION</b>	<b>ID</b>	<b>DESCRIPTION</b>	<b>ID</b>	<b>DESCRIPTION</b>
<b>Aunt Bio</b>	Aunt – Biological	<b>Fath InLaw</b>	Father – In-Law	<b>Niece Bio</b>	Niece – Biological
<b>Aunt NoBio</b>	Aunt – Non-biological	<b>Fath Step</b>	Father-Step	<b>Niece NBio</b>	Niece – Non-biological
<b>Bro Adop</b>	Brother – Adopted	<b>Gdaug Bio</b>	Granddaughter – Biological	<b>Other</b>	Other
<b>Bro Bio</b>	Brother – Biological	<b>GDaug Nbio</b>	Granddaughter – Non-biological	<b>Sis Adop</b>	Sister-Adopted
<b>Bro Foster</b>	Brother – Foster	<b>GrFa Bio</b>	Grandfather –	<b>Sis Bio</b>	Sister-Biological

			Biological		
<b>Bro InLaw</b>	Brother – In-Law	<b>GrFa NBio</b>	Grandfather – Non-biological	<b>Sis Foster</b>	Sister – Foster
<b>Bro Step</b>	Brother – Step	<b>GrMo Bio</b>	Grandmother – Biological	<b>Sis InLaw</b>	Sister – In-Law
<b>Cous Bio</b>	Cousin – Biological	<b>GrMo Nbio</b>	Grandmother – Non-biological	<b>Sis Step</b>	Sister – Step
<b>Cous Nbio</b>	Cousin – Non-biological	<b>GrSon Bio</b>	Grandson – Biological	<b>Son Adopt</b>	Son-Adopted
<b>Daug Adopt</b>	Daughter – Adopted	<b>GrSon Nbio</b>	Grandson – Non-biological	<b>Son Bio</b>	Son – Biological
<b>Daug Bio</b>	Daughter – Biological	<b>Husband</b>	Husband	<b>Son Foster</b>	Son – Foster
<b>Daug Foster</b>	Daughter – Foster	<b>Mother Ado</b>	Mother – Adopted	<b>Son in Law</b>	Son – In-Law
<b>Daug InLaw</b>	Daughter – In-Law	<b>Mother Bio</b>	Mother – Biological	<b>Son Step</b>	Son – Step
<b>Daug Step</b>	Daughter – Step	<b>Mother Fos</b>	Mother – Foster	<b>Signif Oth</b>	Significant Other
<b>Dom Partner</b>	Domestic Partner	<b>Mo In Law</b>	Mother – In-Law	<b>Sig Supp</b>	Significant Support Person
<b>Fath Adop</b>	Father – Adopted	<b>Mo Step</b>	Mother – Step	<b>Uncle Bio</b>	Uncle - Biological
<b>Fath Bio</b>	Father – Biological	<b>Neph Bio</b>	Nephew – Biological	<b>Uncl NBio</b>	Uncle – Non-biological
<b>Fath Fost</b>	Father – Foster	<b>Neph NBio</b>	Nephew – Non-biological	<b>Wife</b>	Wife

Include relevant family information impacting the client: (Further explain family member’s involvement in substance use)

Document Family Strengths.

**CULTURAL INFORMATION:** Write in the area provided. Refer to Help Text.

Experience of stigma, prejudice, or barriers to accessing services. Check appropriate box, describe as appropriate.

**SEXUAL ORIENTATION:** Select all that apply. (*Help Text see Appendix A, page 6*). Complete clinical considerations in text box as indicated.

**GENDER IDENTITY:** Select from choices available. (*Help Text see Appendix A, page 6*). Complete clinical considerations in text box as indicated.

**HISTORY OF SELF-INJURY/SUICIDE/VIOLENCE:** Check the boxes appropriately. A Yes or Refuse/Cannot Assess response requires detailed documentation.

**SUBSTANCE USE INFORMATION:** Check the boxes appropriately and address all fields for tobacco use. A Yes or Refuse/Cannot Assess response requires detailed documentation.

Complete the CRAFFT.

If client has a history of substance use, specify substances used and answer ALL prompts.

History of substance use treatment: Document as appropriate

Does client have a co-occurring disorder (COD): Check appropriate box

Quadrant: Indicate mental health and substance abuse level of need.

Stages of Change: Substance Abuse Recovery. Indicate client’s current Stage of Change.

Describe how substance use impacts current level of functioning if appropriate.

Recommendation for substance use treatment. Check box as appropriate. Explain if Yes is checked.

Gambling: Answer the questions as appropriate. If Yes answer, describe.

## **HIGH RISK ASSESSMENT**

**ASSESSMENT OF IMMEDIATE RISK FACTORS.** Answer all questions with appropriate check box. A Yes or refuse/Cannot Assess response requires detailed documentation.

**PROTECTIVE FACTORS.** Document as appropriate. Use Help Text for further assistance.

**SELF INJURY/SUICIDE/VIOLENCE MANAGEMENT PLAN:** Document as appropriate. Use Help Text for further assistance. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session.

**TARASOFF ASSESSMENT.** Answer all questions with appropriate check box. Document details as necessary. For Yes answers.

**CURRENT DOMESTIC VIOLENCE** Answer all questions with appropriate check box. If Yes, documentation and child/adult protective question is mandatory. Describe the situation.

## **MENTAL STATUS EXAM**

Complete, selecting check boxes as appropriate. Complete the Hallucinations questions at the end of this tab, describing any Yes answers.

## **MEDICAL TAB**

### **ALLERGIES AND ADVERSE MEDICATION REACTIONS.**

Answer appropriately. If “yes” provide detailed information in text box. Share any allergy information with medical staff.

For rest of the Medical Tab, select appropriate check boxes. If there are any Yes answers, give explanations as appropriate.

For the rest of this section, enter the appropriate check marks and text as indicated.

For the “Healing and Health” section: Write in the area provided, using the help text as a guide.

**PREGNANCY/BIRTH HISTORY** Select the appropriate check boxes. A Yes response to any of the questions requires detailed documentation.

**DEVELOPMENTAL MILESTONES.** Select the appropriate check boxes. Document any significant information as appropriate.

**MEDICAL CHECKLIST:** Select the appropriate check boxes. A Yes response to any of the questions requires detailed documentation.

## **BHA SIGNATURE PAGEU**

**CLINICAL FORMULATION:** Document justification and medical necessity in the space provided, using the form’s Help Text as a guide.

MEDICAL NECESSITY MET: Check the appropriate boxes, as indicated.

**CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE:** Provide the dates and check each item as completed.

**Signatures:** The clinician completing the form will sign his/her name with credential on the signature line, and print their name on the second line. Date and Anasazi Staff ID number are documented at the appropriate prompts.

When a clinician needs a co-signature, a qualified clinician will sign, print name, date and enter Anasazi Staff ID as indicated. Refer to Scope of Practice to identify who needs a co-signature.

## Appendix A:

### *Sexual orientation:*

*The type of sexual, romantic, and/or physical attraction someone feels towards others. Who a person is primarily attracted to physically, romantically, and/or emotionally, for example, males, females, both, neither; enduring emotional, romantic or sexual attraction to other people. One's sexual behavior affects the choices one makes in responding to sexual orientation. It is the attraction that shapes one's orientation.)*

*Another sexual orientation: not attracted to either female or male; can refer to a person who is asexual and does not have a sexual attraction or desire to any group of people. Asexuality is not the same as celibacy.*

*Bisexual: is romantic attraction, sexual attraction, or sexual behavior toward both males and females or romantic or sexual attraction to people of any sex of gender identity. A person who is "bi" may not have had an equal amount of sexual experiences with people of the same sex*

*Decline to state: client may be unsure or unwilling to disclose*

*Gay: emotionally, romantically, and/or physically attracted to people of the same sex; although it can be used for any sex (e.g., gay man, gay woman, gay person), "lesbian" is sometimes the preferred term for women who are attracted to women; a gay person may not have had any sexual experience; it is the attraction that shapes sexual orientation.*

*Heterosexual/straight: emotionally, romantically, and/or physically attracted to people of the opposite gender.*

*Lesbian: a woman who is emotionally, romantically, and/or physically attracted to other women; women may also use the term gay to describe themselves; a gay or lesbian woman may not have had any sexual experience.*

*Queer: Think of queer as an umbrella term. It includes anyone who: a) wants to identify as queer and b) who feels somehow outside the societal norm in regards to gender or sexuality. This therefore, could include the person who highly values queer theory concepts and would rather not identify with any particular label, the gender fluid bisexual, the gender fluid heterosexual, the questioning LGBT person, and the person who just doesn't feel like they quite fit in to societal norms and wants to bond with a community over that. Originally pejorative for gay; this term has been reclaimed by some gay men, lesbians, bisexuals and transgendered persons as a self-affirming umbrella term. It is a fluid label as opposed to a solid label.*

*Questioning/Unsure: exploring sexual orientation, gender identity, gender expression)*

### *Gender Identity:*

*The sense of "being" male, female, genderqueer, agender, etc. For some people, gender identity is in accord with physical anatomy. For transgender people, gender identity may differ from physical anatomy or expected societal roles. It is important to note that gender identity, biological sex, and sexual orientation are separate and that you cannot assume how someone identifies in one category based on they identify in another category.)*

*Another gender identity: some of both male and female or neither; refer to genderqueer for more information*

*Genderqueer: Genderqueer is most commonly used to describe a person who feels that his/her gender identity does not fit into the socially constructed "norms" associated with his/her biological sex. Genderqueer identities can include one or more of the following: both man and woman, neither man or woman [genderless], moving between genders [gender fluid], third gender or other gender, those who do not or cannot place a name to their gender, and having an overlap of, or blurred lines between gender identity and sexual orientation.*

*Questioning/unsure: exploring sexual orientation, gender identity, gender expression*

*Transgender: It is frequently used as an umbrella term to refer to people who do not identify with their assigned gender at birth. This includes transsexuals, cross-dressers, genderqueer, drag kings, two spirit people and others. Some transgender people feel like they exist not within one of the two standard gender categories, but rather somewhere in between, beyond, or outside of those two genders.*

# BEHAVIORAL HEALTH ASSESSMENTS

BHS  
UCRM

## (EMERGENCY SCREENING UNIT - ESU)

### COMPLETED BY:

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Nurse Practitioner or Physician Assistant
6. Registered Nurse\*
7. Licensed Psychiatric Technician/Vocational Nurse\*
8. Registered PsyD and Trainee\*

### COMPLIANCE REQUIREMENTS:

1. Must be completed for every client receiving a crisis assessment.
2. Completed at the time a client is assessed for need of hospitalization or any other crisis situation.
3. All fields must be completed or marked N/A.
4. Title 9 Medical Necessity Criteria shall be substantiated.
5. Title 9 Included Diagnosis shall be substantiated.

### DOCUMENTATION STANDARDS:

1. BHA shall be updated in real time to capture any current clinical information.
2. Co-signatures must be completed prior to BHA final approval.
3. Only licensed, registered, waived clinical staff may conduct and claim for BHA (exceptions: Registered PsyD/PhD cannot complete).
4. \*RNs, MHRS, LPT, Registered PsyD/PhD and Trainee may not diagnose a mental illness due to scope of practice, but may conduct and claim for BHA with co-signature of licensed/registered/waivered staff. Therefore a stand-alone diagnosis form shall be completed by a qualified provider prior to completion of BHA.
5. When it is not completed and final approved the system will prevent other servers from launching any assessments that contain shared fields. An assessment that is not final approved is at risk for deletion by another server.
6. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible.
7. A BHA is not valid until it is thoroughly completed and final approved with all required signatures.

**San Diego County Mental Health Services  
BEHAVIORAL HEALTH ASSESSMENT – ESU**

**\*Client Name:**                      **\*Case #:**

**\*Assessment Date**                      **\* Program Name:**

**OTHER AGENCY INVOLVEMENT:**    CWS    Regional Center    Probation  
 Other: \_\_\_\_\_

**\*SOURCE OF INFORMATION**

If a source other than listed on the “Source of Information Table”, specify:

Reports Reviewed:

Agency Involvement: *Include names, relationships, and phone or contact information*

Referral Source:                      If Other, Specify:

**PRESENTING PROBLEMS/NEEDS**    *Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and history of present illness. Summary of client’s request for services including client’s most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors; include experiences of stigma and prejudice, if any.*

**PAST PSYCHIATRIC HISTORY**    *Previous history of symptoms and/or mental health treatment. Describe in chronological order - where, when, and length of time. Include dates and providers related to any prior psychiatric treatment, history, traumatic and/or significant events, and/or trauma related to treatment. Include the most recent periods of stability and the characteristics of those periods.*

**EDUCATION:**

Area(s) of Concern:     Academic                       Employment  
    No issue reported     Other: \_\_\_\_\_

Education (last Grade Completed):  
Failed the following grade(s):

Client has an active 504 Plan:     No                       Yes                       Refuse/Cannot Assess  
Client has an active IEP:             No                       Yes                       Refuse/Cannot Assess  
Special Education:                       No                       Yes                       Refuse/Cannot Assess

Is Client receiving mental health services through a school district?  
 No    Yes    Refuse/Cannot Assess

Describe:

**SOCIAL CONCERNS:**

- Peer/Social Support  No  Yes  Refuse/Cannot Assess
- Substance use by peers  No  Yes  Refuse/Cannot Assess
- Gang affiliations  No  Yes  Refuse/Cannot Assess
- Family/community support system  No  Yes  Refuse/Cannot Assess
- Religious/spirituality  No  Yes  Refuse/Cannot Assess
- Justice system  No  Yes  Refuse/Cannot Assess

A YES response to any of the above requires detailed documentation:

**FAMILY HISTORY:**

Living Arrangement: *Select from Living Arrangement table listed in the Instructions Sheet*

Those living in the home with client:

Have any relatives ever been impacted by the following. Expand below if applicable:

*Select from Relatives table listed in the Instructions Sheet*

Suicidal thoughts, attempts:

Violence:

Domestic Violence:

Substance abuse or addiction:

Other addictions:

Gang Involvement:

Emotional/mental health issues:

Physical Health Issues:

Intellectual developmental disorder:

Developmental delays:

Arrests:

Abuse:

Abuse reported:  N/A  No  Yes  Refuse/Cannot Assess

Include relevant family information impacting the client:

Family Strengths:

**CULTURAL INFORMATION:** *Considerations could include language of client/family, religious/spiritual beliefs, socio-economic background, ethnicity, race, immigration history, age and subculture. Describe distinct cultural and linguistic needs and strengths that may impact treatment.*

**Experience of stigma, prejudice, or barriers to accessing services:**

- No  Yes  Refuse/Cannot Assess

Describe:

**SEXUAL ORIENTATION/GENDER IDENTITY**

- Select One:  Heterosexual  Lesbian  Gay Male  Bisexual  Transgender

Questioning    Intersex    Other    Decline to State    Deferred  
 Clinical Considerations:

**GENDER IDENTITY:** *(Help Text see Appendix A)*

Assigned at birth (Select one):    Male    Female    Decline to state

Current Gender (Select all that apply):

Male    Female    Transgender    Genderqueer  
 Another gender identity    Questioning/Unsure    Decline to state

Clinical Considerations:

**HISTORY OF SELF-INJURY/SUICIDE/VIOLENCE**

History of self-injury (cutting, burning)    No    Yes    Refuse/Cannot Assess  
 History of suicide attempt/s    No    Yes    Refuse/Cannot Assess  
 History of violence toward another    No    Yes    Refuse/Cannot Assess  
 History of significant property destruction    No    Yes    Refuse/Cannot Assess  
 History of domestic violence    No    Yes    Refuse/Cannot Assess  
 History of abuse    No    Yes    Refuse/Cannot Assess  
     Abuse Reported    N/A    No    Yes    Refuse/Cannot Assess

Experience of traumatic event/s    No    Yes    Refuse/Cannot Assess

A YES or REFUSE/CANNOT assess response to any of the above requires detailed documentation:

**SUBSTANCE USE INFORMATION:**

History of substance use?    No    Yes    Refuse/Cannot Assess

**(if yes, specify substances used)**

Name of Drug	Priority	Method of Administration	Age 1 <sup>st</sup> used	Freq- uency of Use	Days of use in last 30 days	Date of last use	Amount of last use	Amount used on a typical Day	Largest Amount Used in One Day

History of substance use treatment:

Does client have a co-occurring disorder (COD):    No    Yes    Refuse/Cannot Assess

When applicable, outline how substance use impacts current level of functioning:

Recommendation for further substance use treatment:    No    Yes    Refuse/Cannot Assess

If Yes:

**HIGH RISK ASSESSMENT TAB**

**ASSESSMENT OF IMMEDIATE RISK FACTORS:** Any “yes” response triggers enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required to prior to end of session.

Direct (past 2 weeks) discharge from 24 hour program  No  Yes  Refuse/Cannot Assess  
*due to suicidal or homicidal crisis* (hospital, IMD, START, residential treatment, etc.)

Current serious thoughts/impulses of hurting/killing self or others:  
*Note if access to fire arms (guns) or other lethal means:*  No  Yes  Refuse/Cannot Assess

Pre-death behaviors/committed to dying  No  Yes  Refuse/Cannot Assess  
(e.g. giving away possessions) and/or current hopelessness/sees no options

Preoccupied with incapacitating or life threatening illness  No  Yes  Refuse/Cannot Assess  
and/or chronic intractable pain and/or catastrophic social loss.

Current command hallucinations, intence paranoid delusions  No  Yes  Refuse/Cannot Assess  
and/or command override symptoms(belief that others control thoughts/actions)

Current behavioral dyscontrol with intense anger/humiliation,  No  Yes  Refuse/Cannot Assess  
recklessness, risk taking, self-injury and/or physical aggression and violence

**Additional Youth Risk Factors:**

Current extreme social alienation, isolation and/or victim  No  Yes  Refuse/Cannot Assess  
of bullying.

A YES or Refuse/Cannot Assess response to any other the above required detailed documentation:

**PROTECTIVE FACTORS:**(strong religious, cultural, or inherent values against harming self/others, strong social support system, positive planning for future, engagement in treatment, valued care giving role (people or pets) and strong attachment/responsibility to others.)

**SELF-INJURY/SUICIDE/VIOLENCE MANAGEMENT PLAN:** (Document enhanced suicide/violence/homicide precautions and/or efforts to transfer to a higher level of care. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session)

**TARASOFF ASSESSMENT:**

Current Violent Impulses and/or Homicidal ideation  No  Yes  Refuse/Cannot Assess  
Toward a reasonably identified victim?

Tarasoff Warning Indicated?  No  Yes  Refuse/Cannot Assess  
If yes, include victim(s) name and contact information (Tarasoff Warning Details):



- Average    Below Average    Above Average    Poor Vocabulary  
 Poor Abstraction    Paucity of Knowledge    Unable to Rate

Mood

- Euthymic    Elevated    Euphoric    Irritable    Depressed    Anxious

Memory

- Normal    Poor Recent    Poor Remote    Inability to Concentrate  
 Confabulation    Amnesia

Motor

- Age Appropriate/Normal    Slowed/Decreased    Psychomotor Retardation  
 Hyperactive    Agitated    Tremors    Tics    Repetitive Motions

Judgment

- Age Appropriate/Normal    Poor    Unrealistic  
 Fair    Limited    Unable to Rate

Insight

- Age Appropriate/Normal    Poor    Fair    Limited    Adequate    Marginal

Command Hallucinations

- No    Yes, specify:

Auditory Hallucinations

- No    Yes, specify:

Visual Hallucinations

- No    Yes, specify:

Tactile Hallucinations

- No    Yes, specify:

Olfactory Hallucinations

- No    Yes, specify:

Delusions

- No    Yes, specify:

Other observations/comments when applicable :

**MEDICAL TAB**

**ALLERGIES AND ADVERSE MEDICATION REACTIONS:**

- No    Yes    Unknown/Not Reported

If Yes, Specify: **(Share this allergy information with your medical staff.):**

Does client have a Primary Care Physician?  No    Yes    Unknown

If No, has client been advised to seek primary care?  No    Yes

Primary Care Physician:

Phone Number:

Seen within the last:  6 months    12 months    Other:

Physical Health issues:

- None at this time    Yes

If Yes, specify:

Is condition followed by Primary Care Physician?  No    Yes    N/A

Physical health problems affecting mental health functioning:

Any known medical condition or past history of abuse that requires special consideration if physical restraint is needed, specifically: breathing problems, significantly overweight, pregnancy, etc?

No       Yes       Refuse/Cannot Assess

If Yes, explain:

Head injuries:       No     Yes

If Yes, specify:

Medical and/or adaptive devices:

Significant Developmental Information (when applicable):

### MEDICAL CHECKLIST

Has the child ever had any of the following:

Speech problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess
Head Banging	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess
Day time wetting	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess
Night time wetting	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess
Poor bowel control	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess
Sleep problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess
Eating problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess
More interested in things than people	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess
Ear infections	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess
High fevers	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess
TB	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess
Seizures or loss of consciousness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess
Medical hospitalizations	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess
Operations	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess
Serious illness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess
Child menstruating	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess
Pregnancies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess
Venereal diseases	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess
Do you know child's HIV status	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Refuse/Cannot Assess

A YES response to any of the above requires detailed documentation:

**DIAGNOSIS** If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Behavioral Health Assessment.

**CLINICAL CONCLUSION:** Justification for diagnosis and medical necessity. Summarize and integrate all information gathered from other sources to render clinical judgments regarding intensity, length of treatment and recommendations for services. Clearly state those emotional or behavioral symptoms that interfere with normal functioning. Include evaluation of client's ability and willingness to solve the presenting problems, addressing both mental health and substance issues from an integrated perspective.



**San Diego County Mental Health Services  
BEHAVIORAL HEALTH ASSESSMENT – ESU  
Instructions**

**CLIENT NAME** - Required Field.  
**ASSESSMENT DATE** – Required Field.

**CASE #** - Required Field.  
**PROGRAM NAME**- Required Field.

**OTHER AGENCY INVOLVEMENT:** Select appropriate check box. If other, explain.

**SOURCE OF INFORMATION-** Required Field. Select from the Source of information Table below. Include the ID and Description in your documentation. If “Other” is selected, please provide information.

<b>ID</b>	<b>Description</b>	<b>ID</b>	<b>Description</b>
AB2726 Asr	AB2726 Assessor	<b>Other</b>	Other
<b>ADS Prov</b>	ADS Recovery Provider	<b>Parent LG</b>	Parent/Legal Guardian
<b>Case Mnager</b>	Case Manager	<b>Parole</b>	Parole Officer
<b>Client</b>	Client	<b>Prev Asst</b>	Previous Assessment
<b>Conservatr</b>	Conservator	<b>Probation</b>	Probation Officer
<b>Family</b>	Family	<b>Soc Worker</b>	Social Worker
<b>Fos Parent</b>	Foster Parent	<b>Teacher</b>	Teacher/School
<b>MD</b>	MD	<b>Therapist</b>	Therapist

**REPORTS REVIEWED:** Enter any reports used as part of the assessment.

**REFERRAL SOURCE:** *(Select from Table below)* If Other, explain in text box.

<b>ID</b>	<b>Description</b>	<b>ID</b>	<b>Description</b>
<b>1</b>	ACL	<b>12</b>	Partners Program
<b>2</b>	CAPS	<b>13</b>	Primary Care Provider/FQHC
<b>3</b>	CWS	<b>14</b>	Probation
<b>4</b>	Case Management Program	<b>15</b>	SARB
<b>5</b>	Crisis Action and Connection (CAC)	<b>16</b>	School
<b>6</b>	ESU	<b>17</b>	Self/Family
<b>7</b>	FFS Hospital	<b>18</b>	Substance Abuse Treatment OP/TRC
<b>8</b>	FFS Provider	<b>19</b>	Substance Abuse Treatment Residential
<b>9</b>	Group Home/Residential Tx Facility	<b>20</b>	TBS
<b>10</b>	OP Clinic/School Based	<b>21</b>	Other
<b>11</b>	PEI Program		

**PRESENTING PROBLEMS/NEEDS:** Write in the area provided, using the help text as a guide.

**PAST PSYCHIATRIC HISTORY:** Write in the area provided, using the help text as a guide.

**EDUCATION:**

Check all “Areas of Concern” boxes that apply. Complete the other prompts as applicable. If client is receiving mental health services through a school district, explain.

**SOCIAL CONCERNS:** Check all boxes as applicable. Give explanations for all “yes” answers

**FAMILY HISTORY:**

**LIVING ARRANGEMENT:** A Required Field.

Select from the Living Arrangement Table below. Include the ID and Description in your documentation.

<b>Living Arrangement</b>		
A-House or Apartment B-House or Apt with Support C-House or Apt with Daily Supervision Independent Living Facility D-Other Supported Housing Program E-Board & Care – Adult F-Residential Tx/Crisis Ctr – Adult	G-Substance Abuse Residential Rehab Ctr H-Homeless/In Shelter I-MH Rehab Ctr (Adult Locked) J-SNF/ICF/IMD K-Inpatient Psych Hospital L-State Hospital M-Correctional Facility	O-Other R-Foster Home-Child S-Group Home-Child (Level 1-12) T-Residential Tx Ctr-Child (Level 13-14) U-Unknown V-Comm Tx Facility (Child Locked) W- Children’s Shelter

Describe all who live in home with client.

**HAVE ANY RELATIVES EVER BEEN IMPACTED BY THE FOLLOWING:** For each listed condition, enter information from the family members table, if applicable, in the spaces provided. Leave blank if there are none:

<b>ID</b>	<b>DESCRIPTION</b>	<b>ID</b>	<b>DESCRIPTION</b>	<b>ID</b>	<b>DESCRIPTION</b>
<b>Aunt Bio</b>	Aunt – Biological	<b>Fath InLaw</b>	Father – In-Law	<b>Niece Bio</b>	Niece – Biological
<b>Aunt NoBio</b>	Aunt – Non-biological	<b>Fath Step</b>	Father-Step	<b>Niece NBio</b>	Niece – Non-biological
<b>Bro Adop</b>	Brother – Adopted	<b>Gdaug Bio</b>	Granddaughter – Biological	<b>Other</b>	Other
<b>Bro Bio</b>	Brother – Biological	<b>GDaug Nbio</b>	Granddaughter – Non-biological	<b>Sis Adop</b>	Sister-Adopted
<b>Bro Foster</b>	Brother – Foster	<b>GrFa Bio</b>	Grandfather – Biological	<b>Sis Bio</b>	Sister-Biological
<b>Bro InLaw</b>	Brother – In-Law	<b>GrFa NBio</b>	Grandfather – Non-biological	<b>Sis Foster</b>	Sister – Foster
<b>Bro Step</b>	Brother – Step	<b>GrMo Bio</b>	Grandmother – Biological	<b>Sis InLaw</b>	Sister – In-Law
<b>Cous Bio</b>	Cousin – Biological	<b>GrMo Nbio</b>	Grandmother – Non-biological	<b>Sis Step</b>	Sister – Step
<b>Cous Nbio</b>	Cousin – Non-biological	<b>GrSon Bio</b>	Grandson – Biological	<b>Son Adopt</b>	Son-Adopted
<b>Daug Adopt</b>	Daughter – Adopted	<b>GrSon Nbio</b>	Grandson – Non-biological	<b>Son Bio</b>	Son – Biological
<b>Daug Bio</b>	Daughter – Biological	<b>Husband</b>	Husband	<b>Son Foster</b>	Son – Foster
<b>Daug Foster</b>	Daughter – Foster	<b>Mother Ado</b>	Mother – Adopted	<b>Son in Law</b>	Son – In-Law
<b>Daug InLaw</b>	Daughter – In-Law	<b>Mother Bio</b>	Mother – Biological	<b>Son Step</b>	Son – Step
<b>Daug Step</b>	Daughter – Step	<b>Mother Fos</b>	Mother – Foster	<b>Signif Oth</b>	Significant Other
<b>Dom Partner</b>	Domestic Partner	<b>Mo In Law</b>	Mother – In-Law	<b>Sig Supp</b>	Significant Support Person
<b>Fath Adop</b>	Father – Adopted	<b>Mo Step</b>	Mother – Step	<b>Uncle Bio</b>	Uncle - Biological
<b>Fath Bio</b>	Father – Biological	<b>Neph Bio</b>	Nephew – Biological	<b>Uncl NBio</b>	Uncle – Non-biological
<b>Fath Fost</b>	Father – Foster	<b>Neph NBio</b>	Nephew – Non-biological	<b>Wife</b>	Wife

For relevant family information impacting the client, and Family Strengths, write in the areas provided.

**CULTURAL INFORMATION:** Document cultural explanations for symptoms in the space provided, using the Help Text as a guide.

Experience of stigma, prejudice, or barriers to accessing services: Check all boxes as applicable. Give explanations as appropriate.

**SEXUAL ORIENTATION/GENDER IDENTITY.** Check all boxes as applicable. Give clinical considerations as appropriate.

**HISTORY OF SELF-INJURY/SUICIDE/VIOLENCE** Select appropriate check boxes. Any YES or REFUSE/CANNOT ASSESS responses require explanation.

**SUBSTANCE USE INFORMATION:** Check all boxes as applicable. Complete the rest of this section by entering the requested text or selecting the appropriate check boxes.

**HIGH RISK ASSESSMENT TAB:** This entire section is required. Check all boxes as applicable. Any YES or Refuse/Cannot Assess response required detailed explanation. Document Protective Factors, and Self-Injury/Suicide/Violence Management Plan sections, using the help text as a guide.  
Signatures: High Risk Assessment must be signed by a licenses/registered clinician. Trainees need co-signatures. Only clinical staff to complete this assessment.

**MENTAL STATUS, POTENTIAL FOR HARM, STRENGTHS, AREAS OF NEED:** Provide answers for items in these domains by selecting the appropriate check boxes or entering requested text in the spaces provided. Consult form Help Texts as available

**MEDICAL TAB**

Allergies and Adverse Medication Reactions: This is Required. Select appropriate check boxes. If Yes, Specify. Share allergy information with medical staff.

For rest of the Medical Tab, select appropriate check boxes. If there are any Yes answers, give explanations as appropriate.

**DIAGNOSIS**

**If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Behavioral Health Assessment.**

**CLINICAL FORMULATION:** Document justification and medical necessity in the space provided, using the form's Help Text as a guide.

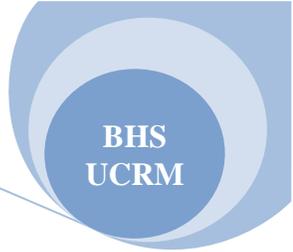
MEDICAL NECESSITY MET: Check the appropriate boxes, as indicated.

**CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE:** Provide the dates and check each item as completed.

**Signatures:** The clinician completing the form will sign his/her name with credential on the signature line, and print their name on the second line. Date and Anasazi Staff ID number are documented at the appropriate prompts.

When a clinician needs a co-signature, a qualified clinician will sign, print name, date and enter Anasazi Staff ID as indicated. Refer to Scope of Practice to identify who needs a co-signature.

# BEHAVIORAL HEALTH ASSESSMENTS



BHS  
UCRM

## COMPLETED BY:

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Nurse Practitioner/Physician Assistant
6. Registered Nurse
7. Licensed Psychiatric Technician/Vocational Nurse
8. Registered PsyD, MHRS and Trainee\*

## COMPLIANCE REQUIREMENTS:

1. Initial BHA shall be completed within 30 days of assignment open.
2. Annual BHA – Program specific BHA must be updated a minimum of every 12 months from the date of the most recent final approved BHA. (Date = final approval date rather than date of assessment).
3. All fields must be completed or marked N/A
4. Title 9 Medical Necessity Criteria shall be substantiated.
5. Title 9 Included Diagnosis shall be substantiated.

## DOCUMENTATION STANDARDS:

1. BHAs shall be updated in real time to capture current clinical information.
2. Co-signatures must be completed prior to BHA final approval.
3. CYF SOC
  - a. Only licensed, registered, waived clinical staff may conduct and claim for BHA (exceptions: \*Registered PsyD/Ph.D and MHRS cannot complete).
  - b. \*A Trainee may only complete a BHA with an approved co-signature of a licensed/registered/waivered staff.
4. A/OA SOC
  - a. \*A MHRS may only complete a BHA with an approved co-signature of a licensed/registered/waivered staff.
5. Include unit/subunit/ and date in text fields to denote program specific entry.
6. Updates should evidence ongoing medical necessity in the presenting problem, clinical conclusion, and other fields as indicated.
7. Prior presenting problem information shall be summarized and relevant information moved to the Past Psychiatric History section.
8. When it is not completed and final approved the system will prevent other servers from launching any assessments that contain shared fields. An Assessment that is not final approved is at risk for deletion by another server.
9. The assessment may be completed in one or more session.
10. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible.
11. A BHA is not valid until it is thoroughly completed and final approved with all required signatures.

**County of San Diego Mental Health Services  
BEHAVIORAL HEALTH ASSESSMENT – START**

\*Client Name:

\*Case #:

\*Assessment Date

\*Program Name:

**BHA START TAB**

**LEGAL STATUS/CASE MANAGER/PAYEE**

Conservator:             None             LPS             Probate             Temporary

Case Manager:  None             SBCM             FSP             Institutional  
 Regional Center             Other

Payee:

Probation Officer:

**\*SOURCE OF INFORMATION:** *Select from Source of Information Table located in the Instructions sheet*

If a source other than listed on the “Source of Information” Table, specify

Reports Reviewed:

\*Referral Source:

If Other, specify:

**PRESENTING PROBLEMS/NEEDS:** *(Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and history of present illness. Summary of client’s request for services including client’s most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors; include experiences of stigma and prejudice, if any):*

**PAST PSYCHIATRIC HISTORY:** *(History of symptoms and/or mental health treatment. Describe in chronological order - where, when, and length of time. Include dates and providers related to any prior psychiatric treatment, history, traumatic and/or significant events, and/or trauma related to treatment. Include the most recent periods of stability and the characteristics of those periods)*

**FAMILY HISTORY:**

Living Arrangement: *Select from Living Arrangement table listed in the Drop Down menu:*

Those living in the home with client:

Have any relatives ever been impacted by the following:

*(Select from Relatives table listed in the Instructions Sheet):* Expand below if applicable.

Suicidal thoughts, attempts:

Violence:

Domestic violence:

Substance abuse or addiction:

Other addictions:

Gang involvement:

Emotional/mental health issues:

Physical health conditions:  
Intellectual developmental disorder:  
Developmental delays:  
Arrests:  
Abuse:

Abuse reported:  N/A  No  Yes  Refuse/Cannot Assess

Include relevant family information impacting the client:

Family strengths:

**EDUCATION:**

Area of Concerns:  Academic  
 Behavioral  
 Social  
 No issue reported  
 Other:

Last grade completed:  
Failed the following grade(s):

Client has an active 504 Plan:  No  Yes  Refuse/Cannot Assess  
Client has an active IEP:  No  Yes  Refuse/Cannot Assess  
Special Education:  No  Yes  Refuse/Cannot Assess  
Is Client receiving mental health services through a school district?  No  Yes  Refuse/Cannot Assess

Describe:

Educational Strengths:

**EMPLOYMENT:**  Does not apply

History of volunteer/community service:  No  Yes  Refuse/Cannot Assess  
History of work experience:  No  Yes  Refuse/Cannot Assess  
Current work experience:  No  Yes  Refuse/Cannot Assess  
Last date worked:

Area of Concerns:  Skills Readiness  
 Barriers  
 Training  
 Job retention  
 No issue reported/NA  
 Other:

Describe:

Employment Strengths:

**SOCIAL CONCERNS:**

Peer/Social Support  No  Yes  Refuse/Cannot Assess  
Substance use by peers  No  Yes  Refuse/Cannot Assess  
Gang affiliations  No  Yes  Refuse/Cannot Assess

Family/community support system  
Religious/spirituality

No  Yes  Refuse/Cannot Assess  
 No  Yes  Refuse/Cannot Assess

A YES response to any of the above requires detailed documentation:

**MILITARY HISTORY:**

Branch: \_\_\_\_\_ Date of Service: \_\_\_\_\_  
Discharge status: \_\_\_\_\_  
Impact of service/combat history: \_\_\_\_\_

**CULTURAL INFORMATION:** *(Considerations could include language of client/family, religious, spiritual beliefs, socio-economic background, ethnicity, race, immigration history, age, and subculture. Describe unique cultural and linguistic needs and strengths that may impact treatment).*

Experience of stigma, prejudice, barriers to accessing services

No  Yes  Refuse/Cannot Assess

Describe:

**SEXUAL ORIENTATION** *(Help Text see Appendix A):*

Select all that apply:

Heterosexual/Straight  Bisexual  Lesbian  Gay  Queer  
 Another sexual orientation  Questioning/Unsure  Decline to State

**GENDER IDENTITY:** *(Help Text see Appendix A)*

Assigned at birth (Select one):  Male  Female  Decline to State

Current Gender (Select all that apply):

Male  Female  Transgender  Genderqueer  
 Another gender identity  Questioning/Unsure  Decline to state

Clinical Considerations:

**HISTORY OF SELF-INJURY/SUICIDE/VIOLENCE:**

History of self-injury (cutting, burning)  No  Yes  Refuse/Cannot Assess  
History of suicide attempt/s:  No  Yes  Refuse/Cannot Assess  
History of violence toward another:  No  Yes  Refuse/Cannot Assess  
History of significant property destruction:  No  Yes  Refuse/Cannot Assess  
History of domestic violence:  No  Yes  Refuse/Cannot Assess  
History of abuse:  No  Yes  Refuse/Cannot Assess  
Abuse reported:  N/A  No  Yes  Refuse/Cannot Assess  
Experience of traumatic event/s:  No  Yes  Refuse/Cannot Assess

A YES or refuse/cannot assess response to any of the above requires detailed documentation:

**SUBSTANCE USE INFORMATION:**

Have you ever used tobacco/nicotine products?  No  Yes  Refuse/Cannot Assess

At what age did you first use tobacco/nicotine products: (Select value from drop down list)

Smoker Status: (Select value from drop down list)

In the past 30 days, what tobacco product did you use most frequently? (Select value from drop down list)

What age did you stop using tobacco/nicotine products?

Has the client been informed of the risks? (Smoking is a serious health risk that leads to cancer, cardiovascular disease and possibility of premature death)  No  Yes  Refuse/Cannot Assess

Have Smoking Cessation Resources been offered?  No  Yes  Refuse/Cannot Assess

History of Substance Use?  No  Yes  Refuse/Cannot Assess

(if yes, specify substances used)

Name of Drug	Priority	Method of Administration	Age 1 <sup>st</sup> used	Freq- uency of Use	Days of use in last 30 days	Date of last use	Amount of last use	Amount used on a typical Day	Largest Amount Used in One Day

History of substance use treatment:

Does client have a co-occurring disorder (COD):  No  Yes  Refuse/Cannot Assess

**Quadrant:**

- Q. I: Low / Low
- Q. II: High / Low
- Q. III: Low / High
- Q. IV: High / High

**Stages of Change: Substance Abuse Recovery**

- Pre-Contemplation
- Contemplation
- Preparation/Determination
- Action
- Maintenance
- Not applicable

When applicable, describe how substance use impacts current level of functioning:

Recommendation for further substance use treatment:  No  Yes  Not applicable  
If Yes:

**Gambling:**

Have you ever felt the need to bet more and more money? No Yes Refuse/Cannot Assess  
 Have you ever had to lie to people important to you about how much you gambled? No Yes Refuse/Cannot Assess  
 If Yes:

**HIGH RISK ASSESSMENT TAB**

**ASSESSMENT OF IMMEDIATE RISK FACTORS:** Any “yes” response triggers enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session.

Direct (past 2 weeks) discharge from 24 hour program *due to suicidal or homicidal crisis* (hospital, IMD, START, residential treatment, etc.) No Yes Refuse/Cannot Assess

Current serious thoughts/impulses of hurting/killing self or others: No Yes Refuse/Cannot Assess  
*Note if access to fire arms (guns) or other lethal means:*

Pre-death behavior/committed to dying (e.g. giving away possessions) and/or current hopelessness/sees no options No Yes Refuse/Cannot Assess

Preoccupied with incapacitating or life threatening illness and/or chronic intractable pain and/or catastrophic social loss No Yes Refuse/Cannot Assess

Current command hallucinations, intense paranoid delusions and/or command override symptoms (belief that others control thoughts/actions) No Yes Refuse/Cannot Assess

Current behavioral dyscontrol with intense anger/humiliation, recklessness, risk taking, self-injury and/or physical aggression and violence No Yes Refuse/Cannot Assess

**Additional Youth Risk Factors:**

Current extreme social alienation, isolation and/or victim of bullying No Yes Refuse/Cannot Assess

A YES or REFUSE/CANNOT Assess response to any of the above requires detailed documentation:

**PROTECTIVE FACTORS:** (strong religious, cultural, or inherent values against harming self/others, strong social support system, positive planning for future, engagement in treatment, valued care giving role (people or pets) and strong attachment/responsibility to others.)

**SELF-INJURY/SUICIDE/VIOLENCE MANAGEMENT PLAN:** (Document enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session.)

**TARASOFF ASSESSMENT:**

**Current Violent Impulses and/or Homicidal ideation toward a reasonably identified victim?** No Yes Refuse/Cannot Assess

Tarasoff Warning Indicated?  No  Yes

If yes, include victim(s) name and contact information (Tarasoff Warning Details):

Reported To:                      Date:

**CURRENT DOMESTIC VIOLENCE?**  No  Yes  Refuse/Cannot Assess

If yes, detailed documentation and child/adult protective services question mandatory. Describe situation:

Child/Adult Protective Services Notification Indicated?  No  Yes

Reported To:                      Date:

**MEDICAL TAB**

**ALLERGIES AND ADVERSE MEDICATION REACTIONS:**  No  Yes  Unknown/Not Reported

If Yes, specify:

(Share this allergy information with your medical staff.)

Medications are recorded in the Doctors Home Page (DHP)

Does client have a Primary Care Physician?  No  Yes  Unknown

If No, has client been advised to seek primary care?  No  Yes

Primary Care Physician:

Phone Number:

Seen within the last:  6 months  12 months  Other:

Hospital of choice (physical health):

Physical Health issues:  None at this time  Yes

If Yes, specify:

Is condition followed by Primary Care Physician?  No  Yes  N/A

Physical health problems affecting mental health functioning:

Head injuries:  No  Yes

If Yes, specify:

Medical and/or adaptive devices:

Significant Developmental Information (when applicable):

Healing and Health:

**MENTAL STATUS EXAM TAB**

Unable to assess at this time.

Level of Consciousness

Alert       Lethargic       Stuporous

Orientation

Person    Place    Day    Month    Year    Current Situation  
 All Normal    None

Appearance

Good Hygiene       Poor Hygiene       Malodorous       Disheveled  
 Reddened Eyes       Normal Weight       Overweight       Underweight

Speech

Normal       Slurred    Loud    Soft    Pressured    Slow    Mute

Thought Process

Coherent    Tangential    Circumstantial    Incoherent    Loose Association

Behavior

Cooperative    Evasive    Uncooperative    Threatening    Agitated    Combative

Affect

Appropriate    Restricted    Blunted    Flat    Labile    Other

Intellect

Average    Below Average    Above Average    Poor Vocabulary  
 Poor Abstraction    Paucity of Knowledge    Unable to Rate

Mood

Euthymic    Elevated    Euphoric    Irritable    Depressed    Anxious

Memory

Normal    Poor Recent    Poor Remote    Inability to Concentrate  
 Confabulation    Amnesia

Motor

Age Appropriate/Normal    Slowed/Decreased    Psychomotor Retardation  
 Hyperactive    Agitated    Tremors    Tics    Repetitive Motions

Judgment

Age Appropriate/Normal    Poor    Unrealistic  
 Fair    Limited    Unable to Rate

Insight

Age Appropriate/Normal    Poor    Fair    Limited    Adequate    Marginal

Command Hallucinations

No    Yes, specify:

Auditory Hallucinations

No    Yes, specify:

Visual Hallucinations

No    Yes, specify:

Tactile Hallucinations

No    Yes, specify:

Olfactory Hallucinations

No    Yes, specify:

Delusions

No    Yes, specify:

Other observations/comments when applicable :

## **CASE MANAGEMENT TAB**

Does not apply to program services

### STRENGTHS/SUPPORT SYSTEMS:

Strengths Model is protected by Copyright (Charles A. Rapp, Ph.D. at the University of Kansas.) Used by San Diego County Mental Health Services with permission.

#### Daily Living Situation

Current Status (*What is going on today? What is available now?*)

Client's Desires and Aspirations (*What do I want?*)

Resources – Social and Personal (*What have I used in the past?*)

#### Financial/Insurance

Current Status (*What is going on today? What is available now?*)

Client's Desires and Aspirations (*What do I want?*)

Resources – Social and Personal (*What have I used in the past?*)

#### Vocational/Educational

Current Status (*What is going on today? What is available now?*)

Client's Desires and Aspirations (*What do I want?*)

Resources – Social and Personal (*What have I used in the past?*)

#### Social Supports

Current Status (*What is going on today? What is available now?*)

Client's Desires and Aspirations (*What do I want?*)

Resources – Social and Personal (*What have I used in the past?*)

#### Health

Current Status (*What is going on today? What is available now?*)

Client's Desires and Aspirations (*What do I want?*)

Resources – Social and Personal (*What have I used in the past?*)

#### Leisure/Recreational

Current Status (*What is going on today? What is available now?*)

Client's Desires and Aspirations (*What do I want?*)

Resources – Social and Personal (*What have I used in the past?*)

#### Spiritual/Cultural

Current Status (*What is going on today? What is available now?*)

Client's Desires and Aspirations (*What do I want?*)

Resources – Social and Personal (*What have I used in the past?*)

Client Priorities (*How does the client prioritize the areas above in importance?*)

**BHA SIGNATURE PAGE TAB**

**Stages of Change: Mental Health Recovery**

- |  |   |
|--|---|
| <input type="checkbox"/> Pre-Contemplation         | <input type="checkbox"/> Contemplation  |
| <input type="checkbox"/> Preparation/Determination | <input type="checkbox"/> Action         |
| <input type="checkbox"/> Maintenance               | <input type="checkbox"/> Not applicable |

**CLINICAL FORMULATION:** (*Justification for diagnosis and medical necessity. Summarize and integrate all information gathered from other sources to render clinical judgments regarding intensity, length of treatment and recommendations for services. Clearly state those emotional or behavioral symptoms that interfere with normal functioning. Include evaluation of client's **strengths**, ability and willingness to solve the presenting problems, addressing both mental health and substance issues from an integrated perspective*)

**MEDICAL NECESSITY MET:**  No  Yes

When "No," note date NOA-A issued [Medi-Cal clients only]:

CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE?  Yes Date:

Local mental health program shall inform Clients receiving mental health services, including parents or guardians of children / adolescents, verbally or in writing that:

- Acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services;
- They retain the right to access other Medi-Cal or Short Doyle/Medi-Cal reimbursable services and have the right to request a change of provider, staff person, therapist, and/or case manager.
- Guide to Medi-Cal Mental Health Services was explained and offered on:
- Grievance and Appeal Process explained and Brochure with form fill and envelope offered on:
- Provider List explained and offered on:
- Mental Health Plan's Notice of Privacy Practices (NPP) was offered on:
- Language/Interpretation services availability reviewed and offered when applicable on:
- Advanced Directive brochure was offered on:
- Voter registration material was offered to client at intake or change of address:

**SHORT TERM ACUTE RESIDENTIAL TREATMENT (START) ONLY:**

- House Guidelines reviewed with client
- Personal Rights explained to client
- Adult/Older Adult Mental Health Outpatient Clinic information provided (includes Urgent Walk-In Services Schedule and Contact Information)
- Primary Care Physician Referrals:

Signature of Clinician Requiring Co-signature:

\_\_\_\_\_  
Signature

Date:

Printed Name

Anasazi ID number:

\*Signature of Clinician Completing/Accepting the Assessment:

\_\_\_\_\_  
Signature

Date:

Printed Name

Anasazi ID number:

Signature of Staff Entering Information (if different from above):

\_\_\_\_\_  
Signature

Date:

Printed Name

Anasazi ID number:

**COMPELTED BY:**

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Nurse Practitioner/Physician Assistant
6. Registered Nurse\*
7. Licensed Psychiatric Technician/Vocational Nurse\*
8. Registered PsyD and Trainee\*

**COMPLIANCE REQUIREMENTS:**

1. Initial assessment shall be completed within 30 calendar days of opening client for TBS servicers (day 1 is counted as the date of assignment).
2. The initial BHA TBA does not meet the need for a BHA, therefore there needs to be current BHA in CCBH and if not than one needs to be completed in addition to the BHA TBS.
3. All fields must be completed or marked N/A.
4. Title 9 Medical Necessity Criteria shall be substantiated.
5. Title 9 Included Diagnosis shall be substantiated.

**DOCUMENTATION STANDARDS:**

1. BHA TBS shall be updated in real time to capture current clinical information.
2. Co-signatures must be completed prior to BHA TBS final approval.
3. Only licensed, registered, waived clinical staff may conduct and claim for BHA TBS (exception: Registered PsyD/PhD cannot complete)
4. \*RNs, MHRS, LPT, Registered PsyD/PhD and Trainee may not diagnose mental illness due to scope of practice, but may conduct and claim for BHA TBS with co-signature of licensed/registered/waivered staff. Therefore a stand-alone diagnosis form shall be completed by a qualified provider prior to completion of BHA TBS.
5. Updates should evidence ongoing medical necessity.
6. The assessment may be completed in one or more session. Each assessment service shall be documented, final approved and claimed individually.
7. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible.
8. A BHA TBS is not valid until it is thoroughly completed and final approved with all required signatures.

**San Diego County Mental Health Services  
INITIAL TBS ASSESSMENT (BHA TBS)**

\*Client Name:

\*Case #:

\*Assessment Date:

\*Program Name #:

**SOURCE OF INFORMATION** (Select from Source of Information Table located in the Instructions sheet):

**RELATIONSHIP** (Choose from Family Member List located in the instruction's sheet):

**Target Behaviors:** (Identify child/youth's specific behaviors/symptoms that jeopardize continued placement in a current facility or are expected to interfere when the child/youth is transitioning to a lower level of residential placement; see table located below):

<b>ID</b>	<b>Description</b>
AWOL	AWOL
Hygiene	Hygiene
Poor Bound	Poor/Inappropriate Boundaries
Meds non	Meds non-compliance
Non comp	Non-compliant Behavior
Opp Def Be	Oppositional Defiant Behavior
Other	Other
Phys Aggr	Physical Aggression
Poor Soc	Poor Social Skills
Prop Dest	Property Destruction
Sch Truan	School Truancy/Tardiness
Self Harm	Self-Harm Behavior
Sex Behav	Sexualized Behavior
Suicidal	Suicidal Behavior
Verb Aggr	Verbal Aggression

If Other, specify:

**Describe Specific Behaviors:** (Identify current frequency, severity, and duration of specific behaviors associated with Target Behaviors. Also identify the desired frequency, severity, and duration):

**Identification of Current Skills:** (Choose from the Current Skills Table):

<b>ID</b>	<b>Description</b>
Feelings	Expresses feelings asso.w prob bx
Predict	Predict problematic bx or situations
Soothe	Able to soothe self
Time Out	Able to take timeouts
Accepts	Accepts consequences
Truthful	Is usually truthful

Client Name:  
Assessment Date:

Case Number:  
Program Name:

Other	Other
Remorse	Shows remorse
Responsibl	Takes responsibility for behavior
Understand	Shows remorse

If Other, specify:

**What interventions/consequences have been effective?**

**Medications (Active and Current Inactivations):**

Med	Start Date	Is Date Estimated Y or N	Dosage/Frequency	Amt. Prescribed	Target Sxs	Taken as Prescribed? Y, N or Unk	Prescribing Physician Name	**	Refills	Stop Date	Reason for Stopping

**\*\*Physician Type:** 1. current psychiatrist (out of network) 2. current PCP 3. previous psychiatrist (out of network) 4. previous PCP

**Other Services or Resources Tried or Considered** (Choose from the table below:

ID	Description
Day Tx	Day Treatment
Fam Tx	Family Therapy
Group TX	Group Therapy
Hospital	Hospitalization
Indiv Tx	Individual Therapy
Meds Tx	Medication Therapy
Probation	Probation
Other	Other
Reg Cntr	Regional Center
Resl Tx	Residential Treatment
SES	SES
TBS	TBS
Wraparound	Wrap-around

If Other, specify:

**What were the results of these services?** (Discuss duration and outcomes of previous treatment and how TBS is justified):

Client Name:  
Assessment Date:

Case Number:  
Program Name:

**Desired outcome/result of TBS services:**

- Prevent Higher Level of Care
- Transition to Lower Level of Care
- Prevent Psychiatric Hospitalization

**Days and Times TBS may be requested, based on problematic behaviors:**

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Saturday
- Sunday

**\*Signature of Clinician Completing/Accepting the Assessment:**

Signature: \_\_\_\_\_ Date:

Printed Name: \_\_\_\_\_ Anasazi ID number: \_\_\_\_\_

**Signature of Staff Entering Information (if different from above):**

Signature: \_\_\_\_\_ Date:

Printed Name: \_\_\_\_\_ Anasazi ID number: \_\_\_\_\_

**San Diego County Mental Health Services  
BHA TBS ASSESSMENT  
Instructions**

**CLIENT NAME:** Required field

**CASE NUMBER:** Required field

**ASSESSMENT DATE:** Required field

**PROGRAM NAME:** Required field

**SOURCE OF INFORMATION-** Enter the name of the person providing information on the client.

<b>ID</b>	<b>Description</b>	<b>ID</b>	<b>Description</b>
AB2726 Asr	AB2726 Assessor	Other	Other
ADS Prov	ADS Recovery Provider	Parent LG	Parent/Legal Guardian
Case Mnager	Case Manager	Parole	Parole Officer
Client	Client	Prev Asst	Previous Assessment
Conservatr	Conservator	Probation	Probation Officer
Family	Family	Soc Worker	Social Worker
Fos Parent	Foster Parent	Teacher	Teacher/School
MD	MD	Therapist	Therapist

**RELATIONSHIP:** Enter the relationship to the client of the person providing assessment information.

**TARGET BEHAVIORS:** Using the table below, list the target behaviors in the space provided. If “other,” then specify as indicated.

<b>ID</b>	<b>Description</b>
AWOL	AWOL
Hygiene	Hygiene
Poor Bound	Poor/Inappropriate Boundaries
Meds non	Meds non-compliance
Non comp	Non-compliant Behavior
Opp Def Be	Oppositional Defiant Behavior
Other	Other
Phys Aggr	Physical Aggression
Poor Soc	Poor Social Skills
Prop Dest	Property Destruction
Sch Truan	School Truancy/Tardiness
Self Harm	Self-Harm Behavior
Sex Behav	Sexualized Behavior
Suicidal	Suicidal Behavior
Verb Aggr	Verbal Aggression

**DESCRIBE SPECIFIC BEHAVIORS:** Use the space provided for narrative text.

**IDENTIFICATION OF CURRENT SKILLS:** Using the table below, list the client’s current skills in the space provided. If “other,” then specify as indicated.

<b>ID</b>	<b>Description</b>
Feelings	Expresses feelings asso.w prob bx
Predict	Predict problematic bx or situations
Soothe	Able to soothe self
Time Out	Able to take timeouts

Accepts	Accepts consequences
Truthful	Is usually truthful
Other	Other
Remorse	Shows remorse
Respsibl	Takes responsibility for behavior
Understand	Shows remorse

**WHAT INTERVENTIONS/CONSEQUENCES HAVE BEEN EFFECTIVE:** Use the space provided for narrative text.

**MEDICATIONS:** List medications, dosages and other pertinent information in the spaces provided.

**OTHER RESOURCES TRIED OR CONSIDERED:** Using the table below, list the other resources tried or considered in the space provided. If “other,” then specify as indicated. Document the results of these services where indicated.

ID	Description
Day Tx	Day Treatment
Fam Tx	Family Therapy
Group TX	Group Therapy
Hospital	Hospitalization
Indiv Tx	Individual Therapy
Meds Tx	Medication Therapy
Probation	Probation
Other	Other
Reg Cntr	Regional Center
Resl Tx	Residential Treatment
SES	SES
TBS	TBS
Wraparound	Wrap-around

**DESIRED OUTCOME/RESULT OF TBS SERVICES:** Choose the appropriate response by marking one of the check boxes listed.

**DAYS AND TIMES TBS MAY BE REQUESTED, BASED ON PROBLEMATIC BEHAVIORS:** Indicate request by check box and documentation in spaces provided.

**SIGNATURES:** The clinician completing the form will sign his/her name with credential on the signature line, and print their name on the second line. Date and Anasazi Staff ID number are documented at the appropriate prompts.

# DIAGNOSIS FORM

## COMPLETED BY:

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Nurse Practitioner
6. Trainee (with a co-signature)\*

## COMPLIANCE REQUIREMENTS:

1. The Diagnosis Form should be completed as soon as possible after assignment opening.
2. The Priority 1 diagnosis must be an Included Title 9 Diagnosis.
3. All areas and fields should be addressed
4. A Diagnosis Form is not considered valid until it is signed and final approved.
  - a. \*In order for a Trainee to provide a mental health diagnosis, it must be approved and thereby co-signed by one of the individuals identified above.

## DOCUMENTATION STANDARDS:

1. Diagnosis Forms shall be reviewed and updated as clinically indicated, or at minimum at 12 months from previous update.
2. A Diagnosis Form that is not final approved is at risk for deletion by another server.
3. Paper Diagnosis Forms are only to be completed when the EHR is not accessible, and the expectation is that the information on those forms is entered into the EHR as promptly as possible.
4. If a Diagnosis Form is completed by a clinician and given to an Admin staff for entry into the EHR must be signed with printed name, ID, and Credential.
5. If the client is open to another provider do not end diagnosis. Rather indicate in the documentation which diagnosis is being addressed within the program completing the Diagnosis Form.
6. For more complete Diagnosis Standards, please refer to the Diagnosis Standards on the Optum website.

**San Diego County Behavioral Health Services  
Diagnosis Form**

New       Update

Client Name:	Case Number:
Review Date:	Unit/SubUnit:

**Provided by External Provider**     Yes     No

If Yes, Diagnosing Clinician (First, Last Name):                      Credential:

**Comments:** (Include Rule outs, reason for Diagnosis changes and any other significant information)

**DIAGNOSIS:** List the appropriate diagnoses. Record as many coexisting mental disorders, general medical conditions, and other factors as are relevant to the care and treatment of the individual.

The Primary Diagnosis should be listed first as priority 1.

ID (ICD-10)	Description	Priority	Begin Date	End Date

**CSI General Medical Condition: (Select all that apply)**

<input type="checkbox"/> 00-No General Medical Condition	<input type="checkbox"/> 25-Deaf/Hearing Impaired	<input type="checkbox"/> 28-Multiple Sclerosis
<input type="checkbox"/> 17-Allergies	<input type="checkbox"/> 12-Diabetes	<input type="checkbox"/> 29-Muscular Dystrophy
<input type="checkbox"/> 16-Anemia	<input type="checkbox"/> 09-Digestive Disorders	<input type="checkbox"/> 15-Obesity
<input type="checkbox"/> 01-Arterial Sclerotic Disease	<input type="checkbox"/> 34-Ear Infections	<input type="checkbox"/> 21-Osteoporosis
<input type="checkbox"/> 19-Arthritis	<input type="checkbox"/> 26-Epilepsy/Seizures	<input type="checkbox"/> 37-Other
<input type="checkbox"/> 35-Asthma	<input type="checkbox"/> 02-Heart Disease	<input type="checkbox"/> 30-Parkinson's Disease
<input type="checkbox"/> 06-Birth Defects	<input type="checkbox"/> 18-Hepatitis	<input type="checkbox"/> 31-Physical Disability
<input type="checkbox"/> 23-Blind/Visually Impaired	<input type="checkbox"/> 03-Hypercholesterolemia	<input type="checkbox"/> 08-Psoriasis
<input type="checkbox"/> 22-Cancer	<input type="checkbox"/> 04-Hyperlipidemia	<input type="checkbox"/> 36-Sexually Transmitted Disease
<input type="checkbox"/> 20-Carpal Tunnel Syndrome	<input type="checkbox"/> 05-Hypertension	<input type="checkbox"/> 32-Stroke
<input type="checkbox"/> 24-Chronic Pain	<input type="checkbox"/> 14-Hyperthyroid	<input type="checkbox"/> 33-Tinnitus
<input type="checkbox"/> 11-Cirrhosis	<input type="checkbox"/> 13-Infertility	<input type="checkbox"/> 10-Ulcers
<input type="checkbox"/> 07-Cystic Fibrosis	<input type="checkbox"/> 27-Migraines	<input type="checkbox"/> 99-Unknown/Not Reported

**Experienced Trauma:**     Yes     No     Unknown/Not Reported

**Signature of Clinician Requiring Co-signature:**

\_\_\_\_\_  
Signature

Date:

**San Diego County Behavioral Health Services  
Diagnosis Form**

Printed Name

Anasazi ID number:

**Signature of Clinician Completing/Accepting the Assessment:**

\_\_\_\_\_  
Signature

Date:

Printed Name

Anasazi ID number:

**Signature of Staff Entering Information (if different from above):**

\_\_\_\_\_  
Signature

Date:

Printed Name

Anasazi ID number:

## HIGH RISK INDEX (HRI)

CLIENT NAME:                      CASE NUMBER:

**HIGH RISK INDEX:** A guide to determining persistent risk level (e.g. mild, moderate, severe) apart from immediate risk indicators. \* Indicates a particularly **SEVERE RISK FACTOR**.

**Demographic and historical factors:**

- |  |                             |                              |   |
|--|-----------------------------|------------------------------|---|
| High risk demographic factors (age, gender, race, social status) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Sexual orientation or gender identity issues                     | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Suicide of 1 <sup>st</sup> degree relative                      | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Access to firearms or lethal means                              | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |

**Comments:**

**Trauma exposure and/or major life stress:**

- |   |                             |                              |   |
|---|-----------------------------|------------------------------|---|
| Witness of suicide  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Military/veteran  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Recent (under 1 year) return from combat zone  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Stressful caretaking role   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Law enforcement (past or present employment)  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Recent/ongoing victimization –commercial sex exploitation, sexual abuse, incest, physical abuse, domestic violence, bullying, or other assault | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Recent and unresolved major loss (people, employment, shelter, pets)   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Catastrophic legal or financial problems - (Recent, within approx. 3 mos.)   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Release from criminal custody – (Recent, within 3 months)   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |

**Comments:**

**Clinical and/or social history:**

- |  |                             |                              |   |
|--|-----------------------------|------------------------------|---|
| Discharge from 24 hour program (hospital, IMD, START, residential treatment, etc.) – (Recent, within 3 months) | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Alcohol/drug residential treatment failure – (Recent, within 3 months)  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Anniversary of important loss, Date:  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Health deterioration of self or significant others – (Recent, within 3 months)                                 | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Gravely disabled – (Recent, within approximately 3 months)   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Current extreme social isolation (real or perceived)   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Immigration/refugee issues   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Justice system involvement (past or present)   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Current gang exposure or involvement   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Homelessness or imminent risk thereof  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Previous attempts to harm self/others   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Experience in handling firearms  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Documented eating disorder   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Sleeplessness  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Psychomotor agitation   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Panic attacks   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Guilt or worthlessness   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Frequent and/or uncontrollable rage   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| *Impulse control problem   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Substance abuse relapse – (Recent, within 3 months)  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Co-occurring mental and substance abuse disorder   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Current abuse or misuse of drugs and other substances  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Significant change in mood – (Recent, within approx. 3 mos.)   | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |

**Comments:**

## HIGH RISK INDEX (HRI)

### **High risk behaviors:**

- |   |                             |                              |   |
|---|-----------------------------|------------------------------|---|
| *Anti-social behavior – (Recent, within approx. 3 mos.)           | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Acts of property damage – (Recent, within approx. 3 mos.)         | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Risk taking or self-destructive acts                              | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Documented borderline, anti-social, or other personality disorder | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |

**Comments:**

### **PROTECTIVE FACTORS**

- |   |                             |                              |   |
|---|-----------------------------|------------------------------|---|
| Strong religious, cultural, or inherent values for prohibition on hurting self/others | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Strong social support system  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Positive planning for future  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Engages in treatment  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Valued care giving role (people or pets)  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |
| Strong attachment/responsibility to others  | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Refuse/Cannot Assess |

**Comments:**

### **Persistent risk level based upon comprehensive review of high risk index and protective factors:**

- Low – no immediate plan required.
- Medium – consider enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. Consult, collaborate and document.
- High – consider enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. Consult, collaborate and document.

**Comments:**

For all unlicensed staff, documentation of a consultation is strongly suggested for Medium and High risk levels identified. For trainees specifically, review with supervisor should occur prior to end of session.

Signature of Staff or Clinician Requiring Co-Signature: \_\_\_\_\_ Date:

Signature of Staff or Clinician Completing/Accepting Assessment: \_\_\_\_\_ Date:

## HIGH RISK ASSESSMENT (HRA)

CLIENT NAME:                      CASE NUMBER:

**ASSESSMENT OF IMMEDIATE RISK FACTORS:** Any “yes” response triggers enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session.

Direct (past 2 weeks) discharge from 24 hour program *due to suicidal or homicidal crisis* (hospital, IMD, START, residential treatment, etc.)                      No    Yes    Refuse/Cannot Assess

Current serious thoughts/impulses of hurting/killing self or others:  
*Note if access to fire arms (guns) or other lethal means:*                      No    Yes    Refuse/Cannot Assess

Pre-death behavior/committed to dying (e.g. giving away possessions) and/or current hopelessness/sees no options                      No    Yes    Refuse/Cannot Assess

Preoccupied with incapacitating or life threatening illness and/or chronic intractable pain and/or catastrophic social loss                      No    Yes    Refuse/Cannot Assess

Current command hallucinations, intense paranoid delusions and/or command override symptoms (belief that others control thoughts/actions)                      No    Yes    Refuse/Cannot Assess

Current behavioral dyscontrol with intense anger/humiliation, recklessness, risk taking, self-injury and/or physical aggression and violence                      No    Yes    Refuse/Cannot Assess

**Additional Youth Risk Factors:**

Current extreme social alienation, isolation and/or victim of bullying                      No    Yes    Refuse/Cannot Assess

**A YES or Refuse/Cannot Assess response to any of the above requires detailed documentation:**

**PROTECTIVE FACTORS:** (strong religious, cultural, or inherent values against harming self/others, strong social support system, positive planning for future, engagement in treatment, valued care giving role (people or pets) and strong attachment/responsibility to others.)

**SELF-INJURY/SUICIDE/VIOLENCE MANAGEMENT PLAN:** (Document enhanced suicide/violence/homicide precautions and/or efforts to transfer to higher level of care. For all unlicensed staff, documentation of a consultation is required. For trainees specifically, review with supervisor is required prior to end of session.)

**TARASOFF ASSESSMENT:**

Current violent impulses and/or homicidal ideation toward a reasonably identified victim?                      No    Yes    Refuse/Cannot Assess

Tarasoff Warning Indicated?                      No    Yes

*If yes, include victim(s) name and contact information (Tarasoff Warning Details):*

Reported To:                      Date:

**CURRENT DOMESTIC VIOLENCE?**                      No    Yes    Refuse/Cannot Assess

*If yes, detailed documentation and child/adult protective services question mandatory. Describe situation:*

## HIGH RISK ASSESSMENT (HRA)

Child/Adult Protective Services Notification Indicated?  
Reported To:                      Date:

No     Yes

Signature of Staff or Clinician Requiring Co-Signature: \_\_\_\_\_ Date:

Signature of Staff or Clinician Completing/Accepting Assessment: \_\_\_\_\_ Date:

# HIGH RISK ASSESSMENT (HRA)

The logo for BHS UCRM is located in the top right corner. It consists of three concentric circles in shades of blue, with the text "BHS" above "UCRM" in white, centered within the innermost circle.

BHS  
UCRM

## **COMPLETED BY:**

1. Any direct service provider delivering services within their scope of practice.\*

## **COMPLIANCE REQUIREMENTS:**

1. The HRA is required as part of the initial assessment process, upon discharge from acute care 24 hour facility and thereafter anytime a client presents with risk factors.
2. When completing, if risk is indicated, the development of a plan to manage safety is required.

## **DOCUMENTATION STANDARDS:**

1. \* Co-signature is required for all non-licensed, registered or waived staff, LVN's and LPT's.
2. If completed by an unlicensed staff, a consultation with a licensed staff needs to take place and be documented in the client record.
3. If completing the HRA on paper, it must be legibly handwritten or typed.
4. There is also the HRI paper form, which is optional to complete if desired to further assess risk.
5. The paper HRA and HRI should be kept in the client chart.

**County of San Diego Mental Health Services  
INITIAL SCREENING-ESU**

**\*Client Name:**

**\*Case #:**

**\*Initial Screening Date:**

**\*Program Name:**

\*Type of Contact:     Telephone     Face-to-Face

Informant Name:                      Relation to Client:

\*Is the client under 18?    Yes     No

**PARENTAL INFORMATION**

Parent Name:                      Relationship *(Select from Relationship Table located in the Instruction Sheet):*

Address:                      Phone:

City/State/Zip:

Employment Phone

Other Information *For additional responsible parent/guardian(s), enter "See Contacts Field Below". Enter any other information that might be helpful in this field.*

**Significant Support Persons** *Include Name, Relationship and Phone:*

**LEGAL INFORMATION**

Legal Consent: *(Select from Legal Status Table located in the Instruction Sheet)*

If other:

Responsible Person:

Relationship *(Select from Relationship Table located in the Instruction Sheet):*

Address:                      Phone:

City/State/Zip:

Employment Phone:

**Client Name:**

**Case #**

**Date of Initial Screening:**

**Program Name:**

**Other Information** Enter other information as needed. For AB2726 clients, enter the party who has educational signing rights. For example: "John Smith has Educational Rights".

**CLIENT INFORMATION:**

Client's Physical Address:

City/State/Zip:

Home Phone:            Work Phone:

School Attending:            Current Grade:

Whom can we call back?

**\*PRESENTING PROBLEM:** Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and summary of client's request for services including client's most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors. Include information on 5150 and Police transport.

\*Urgency Level:     Routine     Emergency     Urgent     Unspecified/Unknown

Currently on 5150?     No             Yes  
 Danger to Self     Danger to Others     Gravely Disabled

Client Requests/Needs: Check all that apply:

Psychiatric Assessment     Psychotherapy     Mental Health Assessment             Other

Is client currently taking medications:     Yes     No

Med	Start Date	Is Date Estimated Y or N	Dosage/Frequency	Amt. Prescribed	Target Sxs	Taken as Prescribed? Y, N or Unk	Prescribing Physician Name	**	Refills	Stop Date	Reason for Stopping

**\*\*Physician Type:** 1. current psychiatrist (out of network) 2. current PCP 3. previous psychiatrist (out of network) 4. previous PCP

**Client Name:**

**Case #**

**Date of Initial Screening:**

**Program Name:**

Current Therapist/Clinician (Include Name and Phone Number):

History of Treatment:  Outpatient  Inpatient  Psychiatric Medications

**POTENTIAL FOR HARM/RISK ASSESSMENT**

\*Current Suicidal Ideation?  No  Yes  Unknown/Refused

Specify plan (vague, passive, imminent):

Access to Means?  No  Yes  Unknown/Refused

Describe:

Previous Attempts?  No  Yes  Unknown/Refused

Describe:

Does the client agree not to hurt self or to seek help prior to acting on suicidal impulse?

No  Yes  Unknown/Refused

Explain:

\*Current Homicidal Ideation?  No  Yes  Unknown/Refused

Specify plan (vague, intent, with/without means):

Identified Victim(s)?  No  Yes Tarasoff Warning Indicated?  No  Yes

Reported To:

Date:

Victim(s) name and contact information {Tarasoff Warning Details):

Acts of Property Damage?  Yes  No Most Recent Date:

Gravely Disabled?  Yes  No

**Client Name:**

**Case #**

**Date of Initial Screening:**

**Program Name:**

\*Current Domestic Violence:       No       Yes  
Describe situation:

Child/Adult Protective Services Notification Indicated?       No       Yes

Reported to:                                  Date:

Specify Domestic Violence Plan (include Child/Adult Protective Services information):

Urine Drug Screen:    Positive    Negative    Pending    Refused    N/A

Breathalyzer:    Positive    Negative    Pending    Refused    N/A

Comments Regarding Factors Increasing Risk:

Justice System Involvement?       Yes    No    Unknown  
If yes, describe recent arrests, probation, sex offender information, et cetera:

Social Security #:

**Insurance:**

No       Yes       MediCal                       Medicare

Other Insurance:

**OUTCOME/DISPOSITION**

\*Referred to:

Referrals

**Client Name:**

**Case #**

**Date of Initial Screening:**

**Program Name:**

- Name
- Address
- City/State/ZIP
- Phone
- Person to Contact
- Directions or Other Instructions

Describe Outcome, Including Plan:

**Signature of Staff Completing Screening:**

\_\_\_\_\_

Date

Time

Printed Name:

Anasazi ID number:

**San Diego County Mental Health Services  
INITIAL SCREENING -- ESU  
Instructions**

**Anasazi Tab 1:**

**TYPE OF CONTACT:** This is a required field. Check box: “Telephone” “Face-to-Face”.

**PROGRAM:** Enter your full program name in the space provided.

**INFORMANT NAME:** Enter the name of the person providing the information for the assessment.

**RELATION TO CLIENT:** Using the table below, enter the information on the form in the space provided.

ID	DESCRIPTION	ID	DESCRIPTION	ID	DESCRIPTION
<b>Aunt Bio</b>	Aunt – Biological	<b>Fath InLaw</b>	Father – In-Law	<b>Niece NBio</b>	Niece – Non-biological
<b>Aunt NoBio</b>	Aunt – Non-biological	<b>Gdaug Bio</b>	Granddaughter – Biological	<b>Other</b>	Other
<b>Bro Adop</b>	Brother – Adopted	<b>GDaug NBio</b>	Granddaughter – Non-biological	<b>Signif Oth</b>	Significant Other
<b>Bro Bio</b>	Brother – Biological	<b>GrFa Bio</b>	Grandfather – Biological	<b>Sig Supp</b>	Significant Support Person
<b>Bro Foster</b>	Brother – Foster	<b>GrFa NBio</b>	Grandfather – Non-biological	<b>Sis Adopt</b>	Sister – Adopted
<b>Bro InLaw</b>	Brother – In-Law	<b>GrMo Bio</b>	Grandmother – Biological	<b>Sis Bio</b>	Sister – Biological
<b>Bro Step</b>	Brother – Step	<b>GrMo NBio</b>	Grandmother – Non-biological	<b>Sis Foster</b>	Sister – Foster
<b>Cous Bio</b>	Cousin – Biological	<b>GrSon Bio</b>	Grandson – Biological	<b>Sis In Law</b>	Sister – In-Law
<b>Cous NBio</b>	Cousin – Non-biological	<b>GrSon NBio</b>	Grandson – Non-biological	<b>Sis Step</b>	Sister – Step
<b>Daug Adopt</b>	Daughter – Adopted	<b>Husband</b>	Husband	<b>Son Adopt</b>	Son – Adopted
<b>Daug Bio</b>	Daughter – Biological	<b>Mother Ado</b>	Mother – Adopted	<b>Son Bio</b>	Son – Biological
<b>Daug Foster</b>	Daughter – Foster	<b>Mother Bio</b>	Mother – Biological	<b>Son Foster</b>	Son – Foster
<b>Daug InLaw</b>	Daughter – In-Law	<b>Mother Fos</b>	Mother – Foster	<b>Son In Law</b>	Son – In-Law
<b>Daug Step</b>	Daughter – Step	<b>Mo In Law</b>	Mother – In-Law	<b>Son Step</b>	Son – Step
<b>Dom Partner</b>	Domestic Partner	<b>Mo Step</b>	Mother – Step	<b>Uncle Bio</b>	Uncle – Biological
<b>Fath Adop</b>	Father – Adopted	<b>Neph Bio</b>	Nephew – Biological	<b>Uncl NBio</b>	Uncle – Non-biological
<b>Fath Bio</b>	Father – Biological	<b>Neph NBio</b>	Nephew – Non-biological	<b>Wife</b>	Wife
<b>Fath Fost</b>	Father – Foster	<b>Niece Bio</b>	Niece – Biological		

**IS CLIENT UNDER 18?** This field is required. Check box “Yes” or “No”.

**PARENTAL INFORMATION:** Enter parent name, relationship (select from relationship table above) address, home phone, employment phone, and any other information that might be helpful.

**SIGNIFICANT SUPPORT PERSONS:** Include name, relationship and phone in space provided.

**LEGAL INFORMATION:**

**Legal Consent:** Select from the LEGAL STATUS table located in the Anasazi user manual. If status is different from the table, explain.

**Responsible Person:** Enter the name of the responsible person.

**Relationship to the client:** Enter the relationship to the client (select from relationship table located in the Anasazi user manual).

Enter address, home phone, employment phone and any other information that might be helpful.

**CLIENT INFORMATION:** Enter client’s physical address, home phone and work phone.

**SCHOOL ATTENDING, CURRENT GRADE, WHOM CAN WE CALL BACK?:** Enter the appropriate information in space provided.

**PRESENTING PROBLEM:** Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and summary of client’s request for services including client’s most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors. Include information on 5150 and Police transport.

**URGENCY LEVEL:** This is a required field. Indicate the appropriate urgency level by selecting the appropriate check box: “Routine” “Emergency” “Urgent” “Unspecified/Unknown”.

**CURRENTLY ON 5150:** Check box: “No” “Yes”. If Yes, specify: “Danger to Self” “Danger to Others” “Gravely Disabled”

**CLIENT REQUESTS/NEEDS:** Check all that apply.

Description	ID
Psychiatric Assessment	P
Psychotherapy	T
Mental Health Assessment	M
Other	O

**CURRENT MEDICATIONS:** Indicate if client is currently taking medications by selecting the appropriate check-boxes “Yes” or “No”. If client is taking psychotropic medications enter in medication table provided in the form.

**CURRENT THERAPIST/CLINICIAN:** Enter current therapist or clinician in space provided.

**HISTORY OF TREATMENT:** Check box: “Outpatient” “Inpatient” or “Psychiatric Medications” by selecting the appropriate check-boxes. Provide a narrative description in the space provided.

Anasazi Tab 2

**POTENTIAL FOR HARM/RISK:**

**Current suicidal ideation:** Mark the appropriate check box “No” “Yes” “Unknown/Refused”. Use the text box to specify plan “Vague” “Passive” “Imminent”.

**Access to Means:** Mark the appropriate check box “No” “Yes” “Unknown/Refused”. Use the text box to describe any information necessary.

**Previous Attempts:** Mark the appropriate check box “No” “Yes” “Unknown/Refused”. Use the text box to describe any information necessary.

**Does client agree not to hurt self or to seek help prior to acting on suicidal impulse:** Mark the appropriate check box “No” “Yes” “Unknown/Refused”. Use the text box to explain any information necessary.

**Current homicidal ideation:** Mark the appropriate check box “No” “Yes” “Unknown/Refused”. Use the text box to specify plan “Vague” “Intent” “With/without means”.

**Identified Victim:** Check box “No” or “Yes”. If yes, answer “Tarasoff Warning Indicated” check box “No” or “Yes”. Answer reported to in text box and date.

**Victim(s) name and contact information (Tarasoff Warning Details):** Enter in text box.

**Acts of property damage:** Check box “No” or “Yes” If yes, enter most recent date. Use the text box to explain any information necessary.

**Gravely Disabled:** Check box “No” or “Yes”. Use the text box to explain any information necessary.

**Current Domestic Violence:** Check box “No” or “Yes”. Use the text box to describe situation.

**SUBSTANCE USE:** Check box: “No” “Yes” “Client Declined to Report”. Enter substances used in table provided.

**Child/Adult Protective Services Notification Indicated:** Check box “No” or “Yes”.

Use text box to indicate “reported to” and “date”.

**Specify Domestic Violence Plan:** (include Child/Adult Protective Services information) Enter information in text box.

**Urine Drug Screen:** Check box “Positive” “Negative” “Pending” “Refused” “N/A” use text boxes to enter any information necessary.

**Breathalyzer:** Check box “Positive” “Negative” “Pending” “Refused” “N/A” use text boxes to enter any information necessary.

**Comments Regarding Factors Increasing Risk:** Text box is provided to enter any information necessary.

**Justice System Involvement:** Check box “Yes” “No” or “Unknown” If yes, describe recent arrests, probation, sex offender information, et cetera in text box provided.

**Anasazi Tab 3**

**SOCIAL SECURITY NUMBER:** Enter client’s social security number.

**INSURANCE:** Check box: “No” or “Yes” If yes, select “Medical” Medicare” or “Other Insurance” and provide policy information.

**OUTCOME/DISPOSITION:** List the referrals made and document the outcome (including plan) in the spaces provided.

**Referred to:** This is a Required Field. Select from Table below.

<b>Referred To:</b> 1-ACT Program 2-ACL,211,or Other Community Support 3-CAPS 4-Case Management Program 5-Clubhouse	6-FFS Hospital 7-FFS Provider 8-Mental Health Res Treatment Facility 9-OP Clinic 10-PEI Program 11-Primary Care Provider/FQHC	12-SDCPH 13-Substance Abuse Treatment – OP 14-Substance Abuse Tx – Residential 15-TBS 16-Other 18-None
--	--	---

**Referrals:** List address, phone number, person to contact, directions and other instructions.

**Describe Outcome, Including Plan:** Describe the outcome including plan in space provided.

**SIGNATURE OF STAFF COMPLETING SCREENING:** Enter the name, credential, date and Anasazi ID number for the Staff completing the screening.

# INITIAL SCREENING

## **COMPLETED BY:**

1. Clinical staff participating in the client contact. May not be completed by clerical staff.

## **COMPLIANCE REQUIREMENTS:**

1. Initial client contact when services are requested (phone or walk-in contact).
2. All clinically appropriate elements should be completed.
3. Data must be entered into the EHR.

## **DOCUMENTATION STANDARDS:**

1. Should be completed on all un-“opened” clients screened for services when: there is a significant issue, the client is not likely to be opened to the program, or client is referred to another agency.
2. Not required if BHA is started/completed on first contact.
3. Initial Screening ESU is only to be used by the Emergency Screening Unit (ESU). All other programs are to use the Initial Screening Form.
4. Every assessment within the EHR must be completed and final approved in a timely manner.
5. When it is not completed and final approved the system will prevent other servers from launching any assessments that contain shared fields. An Assessment that is not final approved is at risk for deletion by another server.
6. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible.
7. The Initial Screening form is not viewed as complete and active until it is final approved.

**County of San Diego Mental Health Services  
INITIAL SCREENING**

**\*Client Name:**

**\*Case #:**

**\*Initial Screening Date:**

**\*Program Name:**

\*Type of Contact:     Telephone     Face-to-Face

Informant Name:

Relation to Client *(Select from Relationship Table located in the Instruction Sheet):*

\*Is the client under 18?    Yes     No

**PARENTAL INFORMATION:**

Parent Name:                      Relationship *(Select from Relationship Table located in the Instruction Sheet):*

Address:                      Phone:

City/State/Zip:

Employment Phone

Other Information *For additional responsible parent/guardian(s), enter "See Contacts Field Below". Enter any other information that might be helpful in this field.*

**LEGAL INFORMATION**

Legal Consent: *(Select from Legal Status Table located in the Instruction Sheet)*

If other:

Responsible Person:

Relationship *(Select from Relationship Table located in the Instruction Sheet):*

Address:                      Phone:

City/State/Zip:

Employment Phone:

Other Information *Enter other information as needed:*

**CLIENT INFORMATION:**

Client's Physical Address:

Client Name:

Case #:

Initial Screening Date:  
City/State/Zip:

Program Name:

Home Phone:            Work Phone:

Whom can we call back?

**\*PRESENTING PROBLEM:** *Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and summary of client's request for services including client's most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors. Include information on 5150 and Police transport.*

\*Urgency Level:     Routine     Emergency     Urgent     Unspecified/Unknown

Initiate Second Effort                      Assigned Staff:

Date Second Effort Initiated:

Comments for Second Effort:

\* Client Requests/Needs: *Check all that apply:*

Psychiatric Assessment     Psychotherapy     Mental Health Assessment     Other

Is client currently taking medications:  Yes     No

Med	Start Date	Is Date Estimated Y or N	Dosage/Frequency	Amt. Prescribed	Target Sxs	Taken as Prescribed? Y, N or Unk	Prescribing Physician Name	**	Refills	Stop Date	Reason for Stopping

**\*\*Physician Type:** 1. current psychiatrist (out of network) 2. current PCP 3. previous psychiatrist (out of network) 4. previous PCP

History of Treatment:  Outpatient     Inpatient     Psychiatric Medications

**POTENTIAL FOR HARM/RISK ASSESSMENT**

\*Current Suicidal Ideation?     No     Yes     Unknown/Refused  
Specify plan (vague, passive, imminent):

**Client Name:**

**Case #:**

**Initial Screening Date:**

**Program Name:**

Access to Means?  No  Yes  Unknown/Refused

Describe:

Previous Attempts?  No  Yes  Unknown/Refused

Describe:

Does the client agree not to hurt self or to seek help prior to acting on suicidal impulse?

No  Yes  Unknown/Refused

Explain:

\*Current Homicidal Ideation?  No  Yes  Unknown/Refused

Specify plan (vague, intent, with/without means):

Identified Victim(s)?  No  Yes Tarasoff Warning Indicated?  No  Yes

Reported To:

Date:

Victim(s) name and contact information {Tarasoff Warning Details):

Acts of Property Damage?  Yes  No Most Recent Date:

Gravely Disabled?  Yes  No

\*Current Domestic Violence:  No  Yes

Describe situation:

Child/Adult Protective Services Notification Indicated?  No  Yes

Reported to:

Date:

Specify Domestic Violence Plan (include Child/Adult Protective Services information):

Client Name:

Case #:

Initial Screening Date:

Program Name:

\*Substance Use?  No  Yes  Client Declined to Report

If Yes, complete table below. (refer to substance use table in instructions)

Name of Drug	Priority	Method of Administration	Age 1 <sup>st</sup> used	Freq- uency of Use	Days of use in last 30 days	Date of last use	Amount of last use	Amount used on a typical Day	Largest Amount Used in One Day

Urine Drug Screen:  Positive  Negative  Pending  Refused  N/A

Breathalyzer:  Positive  Negative  Pending  Refused  N/A

Comments Regarding Factors Increasing Risk:

Justice System Involvement?  Yes  No  Unknown

If yes, describe recent arrests, probation, sex offender information, et cetera:

**OUTCOME/DISPOSITION**

Insurance  No  Yes

MediCal

Medicare

Other Insurance

\*Referred to: Check all that apply

ADS  Hospital/ER  No Referral  Other Community Services

Specialty Mental Health Services

Referrals

Name

Address

**Client Name:**

**Case #:**

**Initial Screening Date:**

**Program Name:**

City/State/ZIP  
Phone  
Person to Contact  
Directions or Other Instructions

Describe Outcome, Including Plan:

**Signature of Staff Completing Screening:**

\_\_\_\_\_

Signature

Date

Time

Printed Name:

Anasazi ID number:

**San Diego County Mental Health Services  
INITIAL SCREENING  
Instructions**

**Anasazi Tab 1:**

**TYPE OF CONTACT:** This is a required field. Check box: “Telephone” “Face-to-Face”.

**PROGRAM:** Enter your full program name in the space provided.

**INFORMANT NAME:** Enter the name of the person providing the information for the assessment.

**RELATION TO CLIENT:** Using the table below, enter the information on the form in the space provided.

ID	DESCRIPTION	ID	DESCRIPTION	ID	DESCRIPTION
<b>Aunt Bio</b>	Aunt – Biological	<b>Fath InLaw</b>	Father – In-Law	<b>Niece NBio</b>	Niece – Non-biological
<b>Aunt NoBio</b>	Aunt – Non-biological	<b>Gdaug Bio</b>	Granddaughter – Biological	<b>Other</b>	Other
<b>Bro Adop</b>	Brother – Adopted	<b>GDaug NBio</b>	Granddaughter – Non-biological	<b>Signif Oth</b>	Significant Other
<b>Bro Bio</b>	Brother – Biological	<b>GrFa Bio</b>	Grandfather – Biological	<b>Sig Supp</b>	Significant Support Person
<b>Bro Foster</b>	Brother – Foster	<b>GrFa NBio</b>	Grandfather – Non-biological	<b>Sis Adopt</b>	Sister – Adopted
<b>Bro InLaw</b>	Brother – In-Law	<b>GrMo Bio</b>	Grandmother – Biological	<b>Sis Bio</b>	Sister – Biological
<b>Bro Step</b>	Brother – Step	<b>GrMo NBio</b>	Grandmother – Non-biological	<b>Sis Foster</b>	Sister – Foster
<b>Cous Bio</b>	Cousin – Biological	<b>GrSon Bio</b>	Grandson – Biological	<b>Sis In Law</b>	Sister – In-Law
<b>Cous NBio</b>	Cousin – Non-biological	<b>GrSon NBio</b>	Grandson – Non-biological	<b>Sis Step</b>	Sister – Step
<b>Daug Adopt</b>	Daughter – Adopted	<b>Husband</b>	Husband	<b>Son Adopt</b>	Son – Adopted
<b>Daug Bio</b>	Daughter – Biological	<b>Mother Ado</b>	Mother – Adopted	<b>Son Bio</b>	Son – Biological
<b>Daug Foster</b>	Daughter – Foster	<b>Mother Bio</b>	Mother – Biological	<b>Son Foster</b>	Son – Foster
<b>Daug InLaw</b>	Daughter – In-Law	<b>Mother Fos</b>	Mother – Foster	<b>Son In Law</b>	Son – In-Law
<b>Daug Step</b>	Daughter – Step	<b>Mo In Law</b>	Mother – In-Law	<b>Son Step</b>	Son – Step
<b>Dom Partner</b>	Domestic Partner	<b>Mo Step</b>	Mother – Step	<b>Uncle Bio</b>	Uncle - Biological
<b>Fath Adop</b>	Father – Adopted	<b>Neph Bio</b>	Nephew – Biological	<b>Uncl NBio</b>	Uncle – Non-biological
<b>Fath Bio</b>	Father – Biological	<b>Neph NBio</b>	Nephew – Non-biological	<b>Wife</b>	Wife
<b>Fath Fost</b>	Father – Foster	<b>Niece Bio</b>	Niece – Biological		

**IS CLIENT UNDER 18?** This field is required. Check box “Yes” or “No”.

**PARENTAL INFORMATION:** Enter parent name, relationship (select from relationship table above) address, home phone, employment phone, and any other information that might be helpful.

**LEGAL INFORMATION:**

**Legal Consent:** Select from the LEGAL STATUS table located in the Anasazi user manual. If status is different from the table, explain.

**Responsible Person:** Enter the name of the responsible person.

**Relationship to the client:** Enter the relationship to the client (select from relationship table located in the Anasazi user manual).

Enter address, home phone, employment phone and any other information that might be helpful.

**CLIENT INFORMATION:** Enter client's physical address, home phone and work phone.

**WHOM CAN WE CALL BACK?:** Enter the appropriate information in space provided.

**PRESENTING PROBLEM:** This is a Required Field. Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and history of present illness. Summary of client's request for services including client's most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behavior, including experiences of stigma and prejudice, if any.

**URGENCY LEVEL:** This is a required field. Indicate the appropriate urgency level by selecting the appropriate check box: "Routine" "Emergency" "Urgent" "Unspecified/Unknown".

**INITIATE SECOND EFFORT:** Check if second effort is initiated. Document assigned staff.

**DATE SECOND EFFORT WAS INITIATED:** Document any comments of second effort in space provided.

**CLIENT REQUESTS/NEEDS:** Check all that apply.

Description	ID
Psychiatric Assessment	P
Psychotherapy	T
Mental Health Assessment	M
Other	O

**CURRENT MEDICATIONS:** Indicate if client is currently taking medications by selecting the appropriate check-boxes "Yes" or "No". If client is taking psychotropic medications enter in medication table provided in the form.

**HISTORY OF TREATMENT:** Check box: "Outpatient" "Inpatient" or "Psychiatric Medications" by selecting the appropriate check-boxes. Provide a narrative description in the space provided.

### Anasazi Tab 2

#### **POTENTIAL FOR HARM/RISK:**

**Current suicidal ideation:** Mark the appropriate check box "No" "Yes" "Unknown/Refused". Use the text box to specify plan "Vague" "Passive" "Imminent".

**Access to Means:** Mark the appropriate check box "No" "Yes" "Unknown/Refused". Use the text box to describe any information necessary.

**Previous Attempts:** This is a Required Field. Mark the appropriate check box "No" "Yes" "Unknown/Refused". Use the text box to describe any information necessary.

**Does client agree not to hurt self or to seek help prior to acting on suicidal impulse:** Mark the appropriate check box “No” “Yes” “Unknown/Refused”. Use the text box to explain any information necessary.

**Current homicidal ideation:** Mark the appropriate check box “No” “Yes” “Unknown/Refused”. Use the text box to specify plan “Vague” “Intent” “With/without means”.

**Identified Victim:** Check box “No” or “Yes”. If yes, answer “Tarasoff Warning Indicated” check box “No” or “Yes”. Answer reported to in text box and date.

**Victim(s) name and contact information (Tarasoff Warning Details):** Enter in text box.

**Acts of property damage:** Check box “No” or “Yes” If yes, enter most recent date. Use the text box to explain any information necessary.

**Gravely Disabled:** Check box “No” or “Yes”. Use the text box to explain any information necessary.

**Current Domestic Violence:** This is a Required Field. Check box “No” or “Yes”. Use the text box to describe situation.

**SUBSTANCE USE:** This is a Required Field. Check box: “No” “Yes” “Client Declined to Report”. Enter substances used in table provided.

**Child/Adult Protective Services Notification Indicated:** Check box “No” or “Yes”.

Use text box to indicate “reported to” and “date”.

**Specify Domestic Violence Plan:** (include Child/Adult Protective Services information) Enter information in text box.

**Urine Drug Screen:** Check box “Positive” “Negative” “Pending” “Refused” “N/A” use text boxes to enter any information necessary.

**Breathalyzer:** Check box “Positive” “Negative” “Pending” “Refused” “N/A” use text boxes to enter any information necessary.

**Comments Regarding Factors Increasing Risk:** Text box is provided to enter any information necessary.

**Justice System Involvement:** Check box “Yes” “No” or “Unknown” If yes, describe recent arrests, probation, sex offender information, et cetera in text box provided.

### **Anasazi Tab 3**

**INSURANCE:** Check box: “No” or “Yes” If yes, select “Medical” “Medicare” or “Other Insurance” and provide policy information.

**OUTCOME/DISPOSITION:** List the referrals made and document the outcome (including plan) in the spaces provided.

**Referred to:** This is a Required Field. Select from Table below.

<b>Referred To:</b> 1-ACT Program 2-ACL,211,or Other Community Support 3-CAPS 4-Case Management Program 5-Clubhouse	6-FFS Hospital 7-FFS Provider 8-Mental Health Res Treatment Facility 9-OP Clinic 10-PEI Program 11-Primary Care Provider/FQHC	12-SDCPH 13-Substance Abuse Treatment – OP 14-Substance Abuse Tx – Residential 15-TBS 16-Other 18-None
--	--	---

**Referrals:** List address, phone number, person to contact, directions and other instructions.

**Describe Outcome, Including Plan:** Describe the outcome including plan in space provided.

**SIGNATURE OF STAFF COMPLETING SCREENING:** Enter the name, credential, date and Anasazi ID number for the Staff completing the screening.

**San Diego County Mental Health Services**  
**SAFETY ALERTS**  
**Instructions**

This Form, when completed in Anasazi, will auto-populate the top portion of the Face Sheet.

The Face Sheet in Anasazi is designed to pull information from other forms only and can not be changed or updated on its own. Therefore, any change or update that needs to be made to Safety Alert information will require a new Safety Alert form to be completed.

**PROGRAM NAME:** Enter your full program name in the space provided.

**DATE COMPLETED:** Enter the date the information

**ALLERGIES AND ADVERS MEDICATION REACTIONS:** Select the appropriate check-box from those provided. If “Yes,” document details in the space provided.

**SAFETY ALERTS:** Using the table below, select the appropriate concern(s) and list on the form in the spaces provided. Provide narrative documentation in the space provided.

<b>ID</b>	<b>Description</b>
Tarasoff	Previous history of Tarasoff
Con substance	Hx of prog shop for control substances
Suicide	Hx of near lethal suicide attempts
Comnd Hal	Command Hallucinations
Violence	History of violence towards staff
Other	Other

**SIGNATURE:** Enter the name, credential, date and Anasazi ID number for the staff completing the screening.

# SAFETY ALERTS

## **COMPLETED BY:**

1. Clinical staff that have completed a thorough evaluation of the safety risks.

## **COMPLIANCE REQUIREMENTS:**

1. Only to be completed for a client that requires a Safety Alert.
2. All clinically appropriate elements should be completed.
3. The Safety Alert shall be updated when the alert no longer pertains to the client.

## **DOCUMENTATION STANDARDS:**

1. CYF SOC
  - a. Does not allow the Safety Alert to be completed by an MHRS staff.
    - i. This includes: 0-5 kids, children, ESU, and TBS
2. Safety Alerts should be used by the clinical to alert other clinicians of a possible safety risk with the client.
3. The clinician shall exercise caution in selecting from the list as it will be visible on the client FaceSheet.
4. It is expected that clinical staff consult with a supervisors and/or peers before determining a system-wide Safety Alert is warranted.
5. Every assessment within the EHR must be completed and final approved in a timely manner.
6. When it is not completed and final approved, the system will prevent other servers from launching any assessments that contain shared fields. An assessment that is not final is at risk for deletion by another server.
7. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible.
8. Assessments are not considered valid until they are thoroughly completed and final approved with all required signatures.

**\*Client Name:**

**\*Case #:**

**\*Date:**

**\*Program Name:**

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San Diego County Mental Health Services  
**SAFETY ALERTS**

\*Allergies and Adverse Medication Reactions:  No  Unknown/Not Reported  Yes  
If Yes, specify:

**Safety Alerts**

*Check all that apply:*

- Command Hallucinations
- Other
- Hx of program shopping for control subst
- Hx of near lethal suicide attempts
- Hx of Tarasoff
- Hx of violence towards staff

**Signature of Staff Member Obtaining Information:**

\_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Signature

Printed Name: \_\_\_\_\_ Anasazi ID: \_\_\_\_\_

**Signature of Staff Entering Information (if different from above):**

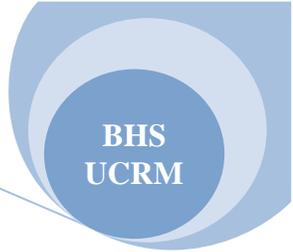
\_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Signature

Printed Name: \_\_\_\_\_ Anasazi ID: \_\_\_\_\_

# OUTCOME EVALUATIONS

## Section 3

# CHILD AND ADOLESCENT MEASUREMENT SYSTEM (CAMS)

The logo for BHS UCRM is located in the top right corner. It consists of three concentric circles in shades of blue, with the text "BHS" above "UCRM" in the center.

BHS  
UCRM

## **COMPLETED BY:**

1. Parent/guardian
2. Client
3. When no parent/guardian is available, staff may be in the role of caregiver and complete measure, noting it was completed by clinician/staff.

## **COMPLIANCE REQUIREMENTS:**

1. Provided to caregivers of youth aged 5 – 18+ and to youth 11 and up at:
  - a. Admission into the program (within the initial 30 days of assignment open).
  - b. The authorization/UM cycle
  - c. Upon discharge
2. Enter score into DES/COSE – these scores are not entered into the EHR.
3. All elements should be completed.

## **DOCUMENTATION STANDARDS:**

1. Completed tools and summary sheets are to be filed in the hybrid chart.
2. If the summary sheet presents alerts, it is good practice to document that these have been addressed.
3. Medication only cases are exempt from completing CAMS.
4. For questions and to obtain tools as well as direction for data entry – contact CASRC
  - a. [soce@casrc.org](mailto:soce@casrc.org)
  - b. 858-966-7703 ext 3508







Client ID Number

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**Instructions:** Think about the things you do and how you feel. Fill in the circle that best describes you.

	Never <sub>1</sub>	Sometimes	Often
1. I help others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I have 2 or more friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I understand the consequences of my behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I have an interest in the future	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I have good relationships with adults outside my family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. I am confident (not easily embarrassed)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. I have a good relationship with my family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. I am able to concentrate/pay attention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. I am able to plan and organize	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. I participate in activities (sports, arts, hobbies)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. I take responsibility for tasks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. I handle criticism well	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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**Instructions:** Think about your behavior over the Last Two Months. Fill in the circle that best describes you.

	No <sub>0</sub>	Yes <sub>1</sub>
1. Had contact with police	<input type="radio"/>	<input type="radio"/>
2. Used alcohol	<input type="radio"/>	<input type="radio"/>
3. Ran away	<input type="radio"/>	<input type="radio"/>
4. Used illegal drugs	<input type="radio"/>	<input type="radio"/>
5. Attempted suicide/hurt self	<input type="radio"/>	<input type="radio"/>
6. Set fires	<input type="radio"/>	<input type="radio"/>
7. Cruel to animals	<input type="radio"/>	<input type="radio"/>
8. Hurt or cut myself.	<input type="radio"/>	<input type="radio"/>

**Instructions:**

Think about your behavior and whether it has caused problems for you. Fill in the circle that is most like you.

How often has your behavior caused problems in each of the following areas?

	Never <sub>1</sub>	Sometimes <sub>2</sub>	Often <sub>3</sub>	Almost Always <sub>4</sub>
1. Home and family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. School	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Friendships with peers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Leisure (free time) activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. How long have you had problems?

Less than a month	1 - 3 months	4 - 6 months	7 - 12 months	13 - 17 months	18 - 24 months	More than two years
<input type="radio"/> <sub>1</sub>	<input type="radio"/> <sub>2</sub>	<input type="radio"/> <sub>3</sub>	<input type="radio"/> <sub>4</sub>	<input type="radio"/> <sub>5</sub>	<input type="radio"/> <sub>6</sub>	<input type="radio"/> <sub>7</sub>

**Instructions:** Think about your life and how you are feeling about the future. Fill in the circle that best describes you.

	Never <sub>1</sub>	Sometimes <sub>2</sub>	Often <sub>3</sub>
1. I am happy with my life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I have what I need in life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. My life is going well	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I have all the support from my family or friends that I need	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I am able to accomplish the things I want to do in my life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. I feel good about what's going on in my life right now	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. I wish my life was different than it is right now	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. I am able to do the kinds of things that other kids my age can do	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. There are people I can count on to help me out if I need it	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. I have more stress and pressure in my life than I can handle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**COMPLETED BY:**

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Nurse Practitioner

**COMPLIANCE REQUIREMENTS:**

1. Only completed for CYF SOC on all clients open to the identified unit/subunit.
2. Completed at:
  - a. Admission into the program (within the initial 30 days of assignment open).
  - b. Authorization/UM cycle
  - c. Upon discharge (within 7 days from date of closing assignment).
3. Data must be entered into the Electronic Health Record. Additionally, this data must be entered into the DES/SOCE.

**DOCUMENTATION STANDARDS:**

1. For each category, a level of severity (1-9) must be marked, along with the adjectives or phrases that describe the child's symptoms or assets.
2. Medication only areas are exempt from completing CFARS.
3. Clinicians are expected to complete certification on the rating system tool prior to utilizing the tool through the website at: <http://outcomes.fmhi.usf.edu/cfars.cfm>.
4. For questions contact CASRC:
  - a. [soce@casrc.org](mailto:soce@casrc.org)
  - b. 858-966-7703 ext 3508
5. Every assessment within the EHR must be completed and final approved in a timely manner.
6. When it is not completed and final approved, the system will prevent other servers from launching any assessments that contain shared fields. An assessment that is not final approved is at risk for deletion by another server.
7. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible.

**San Diego County Mental Health Services**  
**Children's Functional Assessment Rating Scale-CFARS**  
 Copyright held by University of South Florida, John C. Ward, Jr., Ph.D.

**\*Client Name:** \_\_\_\_\_

**\*Case #:** \_\_\_\_\_

**\*Date:** \_\_\_\_\_

**\*Program Name:** \_\_\_\_\_

Type of Assessment:

- |                                    |   |
|------------------------------------|---|
| <input type="checkbox"/> Admission | <input type="checkbox"/> # Of Months      |
| <input type="checkbox"/> 3 Month   | <input type="checkbox"/> School Based     |
| <input type="checkbox"/> 6 Month   | <input type="checkbox"/> Discharge        |
| <input type="checkbox"/> 9 Month   | <input type="checkbox"/> Admin. Discharge |

Admission Date: \_\_\_\_\_

**Problem Severity Ratings**

Use the scale below to rate the child/youth's current [last three weeks] level of severity for each category.

A rating from 1-9 is required for each major category. Check as many symptoms as indicated under each major category.

1 No problem	2 Less than Slight	3 Slight Problem	4 Slight to Moderate	5 Moderate	6 Moderate to Severe	7 Severe Problem	8 Severe to Extreme	9 Extreme Problem
<b>*Depression</b>				<b>*Anxiety</b>				
<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Happy	<input type="checkbox"/> Sleep Problems		<input type="checkbox"/> Anxious/Tense	<input type="checkbox"/> Worried/ Fearful	<input type="checkbox"/> Obsessive/Compulsive		
<input type="checkbox"/> Sad	<input type="checkbox"/> Lacks Energy / Interest		<input type="checkbox"/> Hopeless	<input type="checkbox"/> Phobic	<input type="checkbox"/> Guilt	<input type="checkbox"/> Anti-Anxiety Meds		
<input type="checkbox"/> Irritable	<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Anti-Dep. Meds		<input type="checkbox"/> Calm	<input type="checkbox"/> Panic			
<b>*Hyperactivity</b>				<b>*Thought Process</b>				
<input type="checkbox"/> Manic	<input type="checkbox"/> Inattentive		<input type="checkbox"/> Agitated	<input type="checkbox"/> Illogical		<input type="checkbox"/> Delusional	<input type="checkbox"/> Hallucinations	
<input type="checkbox"/> Sleep Deficit		<input type="checkbox"/> Overactive / Hyperactive		<input type="checkbox"/> Mood Swings	<input type="checkbox"/> Paranoid		<input type="checkbox"/> Ruminative	<input type="checkbox"/> Command Hallucinations
<input type="checkbox"/> Pressured Speech	<input type="checkbox"/> Relaxed		<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Derailed Thinking		<input type="checkbox"/> Loose	<input type="checkbox"/> Intact	
<input type="checkbox"/> ADHD Meds		<input type="checkbox"/> Anti-Manic Meds		<input type="checkbox"/> Oriented		<input type="checkbox"/> Disoriented	<input type="checkbox"/> Anti-Psych. Med	
<b>*Cognitive Performance</b>				<b>*Medical / Physical</b>				
<input type="checkbox"/> Poor Memory		<input type="checkbox"/> Low Self-Awareness			<input type="checkbox"/> Acute Illness		<input type="checkbox"/> Hypochondria	<input type="checkbox"/> Good Health
<input type="checkbox"/> Poor Concentration/Attention		<input type="checkbox"/> Developmental Disability			<input type="checkbox"/> CNS Disorder		<input type="checkbox"/> Chronic Illness	<input type="checkbox"/> Need Med./Dental Care
<input type="checkbox"/> Insightful		<input type="checkbox"/> Concrete Thinking			<input type="checkbox"/> Pregnant		<input type="checkbox"/> Poor Nutrition	<input type="checkbox"/> Enuretic/ Encopretic
<input type="checkbox"/> Impaired Judgement		<input type="checkbox"/> Slow Processing			<input type="checkbox"/> Eating Disorder		<input type="checkbox"/> Seizures	<input type="checkbox"/> Stress-Related Illness
<b>*Traumatic Stress</b>				<b>*Substance Use</b>				
<input type="checkbox"/> Acute		<input type="checkbox"/> Dreams/Nightmares			<input type="checkbox"/> Alcohol		<input type="checkbox"/> Dependence	<input type="checkbox"/> Drugs(s)
<input type="checkbox"/> Chronic		<input type="checkbox"/> Detached			<input type="checkbox"/> Abuse		<input type="checkbox"/> Cravings/Urges	<input type="checkbox"/> Over the Counter Drugs
<input type="checkbox"/> Avoidance		<input type="checkbox"/> Repression/Amnesia			<input type="checkbox"/> DUI		<input type="checkbox"/> I.V. Drugs	<input type="checkbox"/> Abstinence
<input type="checkbox"/> Upsetting Memories		<input type="checkbox"/> Hypervigilance			<input type="checkbox"/> Recovery		<input type="checkbox"/> Med. Control	<input type="checkbox"/> Interfere w/Functioning
<b>*Interpersonal Relationships</b>				<b>*Behavior in "Home" Setting</b>				
<input type="checkbox"/> Problems w/Friends		<input type="checkbox"/> Diff. Establ./ Maintain Relationships			<input type="checkbox"/> Disregards Rules		<input type="checkbox"/> Defies Authority	
<input type="checkbox"/> Poor Social Skills		<input type="checkbox"/> Age-Appropriate Group Participation			<input type="checkbox"/> Conflict w/Sibling or Peer		<input type="checkbox"/> Conflict w/Parent or Caregiver	
<input type="checkbox"/> Adequate Social Skills		<input type="checkbox"/> Supportive Relationships			<input type="checkbox"/> Conflict w/Relative		<input type="checkbox"/> Respectful	
<input type="checkbox"/> Overly Shy					<input type="checkbox"/> Responsible			
<b>*ADL Functioning</b> (Not Age Appropriate In:)				<b>*Socio-Legal</b>				
<input type="checkbox"/> Handicapped		<input type="checkbox"/> Communication		<input type="checkbox"/> Self-Care	<input type="checkbox"/> Disregards Rules		<input type="checkbox"/> Offense/Property	<input type="checkbox"/> Offense/Person
<input type="checkbox"/> Permanent Disability		<input type="checkbox"/> Hygiene		<input type="checkbox"/> Recreation	<input type="checkbox"/> Fire Setting		<input type="checkbox"/> Probation/Parole	<input type="checkbox"/> Pending Charges
<input type="checkbox"/> No Known Limitations		<input type="checkbox"/> Mobility		<input type="checkbox"/> Dishonest		<input type="checkbox"/> Use/Con Other(s)		<input type="checkbox"/> Incompetent
				<input type="checkbox"/> Detention/ Commitment				<input type="checkbox"/> Street Gang Member
<b>*Select: <input type="checkbox"/> Work <input type="checkbox"/> School</b>				<b>*Danger to Self</b>				
<input type="checkbox"/> Absenteeism		<input type="checkbox"/> Poor Performance		<input type="checkbox"/> Regular Attendance	<input type="checkbox"/> Suicidal Ideation		<input type="checkbox"/> Self-Mutilation	<input type="checkbox"/> Past Attempt
<input type="checkbox"/> Dropped Out		<input type="checkbox"/> Learning Disabilities		<input type="checkbox"/> Seeking Employment	<input type="checkbox"/> "Risk-Taking" Behavior		<input type="checkbox"/> Self-Injury	<input type="checkbox"/> Serious Self-Neglect
<input type="checkbox"/> Employed		<input type="checkbox"/> Doesn't Read/Write		<input type="checkbox"/> Tardiness	<input type="checkbox"/> Recent Attempt		<input type="checkbox"/> Inability to Care for Self	<input type="checkbox"/> Current Plan
<input type="checkbox"/> Defies Authority		<input type="checkbox"/> Not Employed		<input type="checkbox"/> Suspended				
<input type="checkbox"/> Disruptive		<input type="checkbox"/> Terminated/ Expelled		<input type="checkbox"/> Skips Class				
<b>*Danger to Others</b>				<b>*Security/ Management Needs</b>				
<input type="checkbox"/> Violent Temper		<input type="checkbox"/> Threatens Others			<input type="checkbox"/> Home w/o Supervision		<input type="checkbox"/> Suicide Watch	
<input type="checkbox"/> Causes Serious Injury		<input type="checkbox"/> Homicidal Ideation			<input type="checkbox"/> Behavior Contract		<input type="checkbox"/> Locked Unit	
<input type="checkbox"/> Use of Weapons		<input type="checkbox"/> Homicidal Threats			<input type="checkbox"/> Protection from Others		<input type="checkbox"/> Seclusion	
<input type="checkbox"/> Assaultive		<input type="checkbox"/> Homicide Attempt			<input type="checkbox"/> Home w/Supervision		<input type="checkbox"/> Run/Escapes Risk	
<input type="checkbox"/> Cruelty to Animals		<input type="checkbox"/> Accused of Sexual Assault			<input type="checkbox"/> Restraint		<input type="checkbox"/> Involuntary Exam/ Commit.	
<input type="checkbox"/> Physically Aggressive		<input type="checkbox"/> Does Not Appear Dangerous to Others			<input type="checkbox"/> Time-Out		<input type="checkbox"/> PRN	
					<input type="checkbox"/> Monitored House Arrest		<input type="checkbox"/> One-to-One Supervision	

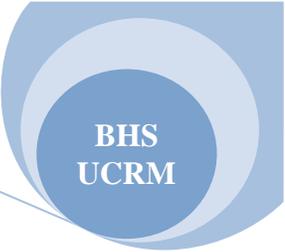
**\*Signature of Staff Member Obtaining Information:** \_\_\_\_\_

Name: \_\_\_\_\_ Anasazi Staff ID: \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Staff Entering Information (If different from above):** \_\_\_\_\_

Name: \_\_\_\_\_ Anasazi Staff ID: \_\_\_\_\_ Date: \_\_\_\_\_

# EYBERG CHILD BEHAVIOR INVENTORY (ECBI)

The logo for BHS UCRM is located in the top right corner. It consists of three concentric blue circles of varying shades, with the text "BHS" above "UCRM" in white, centered within the innermost circle.

BHS  
UCRM

## **COMPLETED BY:**

1. Parent/guardian

## **COMPLIANCE REQUIREMENTS:**

1. Caregivers complete for children aged 0-5.
2. Completed at:
  - a. Admission into the program (within the initial 30 days of assignment open).
  - b. Discharge (within 7 days of closing assignment).
3. Clinician will score the assessment and then data must be entered into the DES/SOCE database.

## **DOCUMENTATION STANDARDS:**

1. Medication only program are exempt from completing the ECBI.
2. The completed tool should be filed into the hybrid chart.
3. These scores are not entered into the EHR.
4. For questions and to obtain the tools, as well as for directions for data entry, contact:
  - a. CASRC
  - b. [soce@casrc.org](mailto:soce@casrc.org)
  - c. 858-966-7703 ext 3508

**COMPLETED BY:**

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Nurse Practitioner
6. Case Manager

**COMPLIANCE REQUIREMENTS:**

1. Completed at assessment, every 6 months and at discharge.
2. All elements should be completed.

**DOCUMENTATION STANDARDS:**

1. Completed for all adults opened to Outpatient and Case Management programs.
2. This is an online questionnaire that should be printed out and kept in the hybrid chart.
3. Online Website:
  - a. <https://homs.ucsd.edu/login.aspx>

# Recovery Scale: IMR Clinician Version

DATE: 

		/			/				

STAFF ID #: 

						/			

CLIENT CASE #: 

--	--	--	--	--	--	--	--	--	--

UNIT/SUB-UNIT: 

--	--	--	--	--	--	--	--	--	--

1. Progress towards personal goals: In the past 3 months, s/he has come up with...

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
No personal goals	A personal goal, but has not done anything to finish the goal	A personal goal and made it a little way toward finishing it	A personal goal and has gotten pretty far in finishing the goal	A personal goal and has finished it

2. Knowledge: How much do you feel your client knows about symptoms, treatment, coping strategies (coping methods), and medication?

<input type="radio"/>				
Not very much	A little	Some	Quite a bit	A great deal

3. Involvement of family and friends in my mental health treatment: How much are people like family, friends, boyfriends/girlfriends, and other people who are important to your client (outside the mental health agency) involved in his/her mental health treatment?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not at all	Only when there is a serious problem	Sometimes, like when things are starting to go badly	Much of the time	A lot of the time and they really help with his/her mental health

4. Contact with people outside of my family: In a normal week, how many times does s/he talk to someone outside of his/her family (like a friend, co-worker, classmate, roommate, etc.)

<input type="radio"/>				
0 times/week	1-2 times/week	3-4 times/week	6-7 times/week	8 or more times/week

5. Time in Structured Roles: How much time does s/he spend working, volunteering, being a student, being a parent, taking care of someone else or someone else's house or apartment? That is, how much time does s/he spend in doing activities for or with another person that are expected of him/her? (This would not include self-care or personal home maintenance.)

<input type="radio"/>				
2 hours or less/week	3-5 hours/week	6-15 hours/week	16-30 hours/week	More than 30 hours/wk

6. Symptom distress: How much do symptoms bother him/her?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Symptoms really bother him/her a lot	Symptoms bother him/her quite a bit	Symptoms bother him/her somewhat	Symptoms bother him/her very little	Symptoms don't bother him/her at all

7. Impairment of functioning: How much do symptoms get in the way of him/her doing things that s/he would like to do or need to do?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Symptoms really get in his/her way a lot	Symptoms get in his/her way quite a bit	Symptoms get in his/her way somewhat	Symptoms get in his/her way very little	Symptoms don't get in his/her way at all

8. Relapse Prevention Planning: Which of the following would best describe what s/he knows and has done in order not to have a relapse?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Doesn't know how to prevent relapses	Knows a little, but hasn't made a relapse prevention plan	Knows 1 or 2 things to do, but doesn't have a written plan	Knows several things to do, but doesn't have a written plan	Has a written a plan and has shared it with others

9. Relapse of Symptoms: When is the last time s/he had a relapse of symptoms (that is, when his/her symptoms have gotten much worse)?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Within the last month	In the past 2 to 3 months	In the past 4 to 6 months	In the past 7 to 12 months	Hasn't had a relapse in the past year

# Recovery Scale: IMR Clinician Version

DATE: 

		/			/				

CLIENT CASE #: 

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STAFF ID #: 


UNIT/SUB-UNIT: 

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10. Psychiatric Hospitalizations: When is the last time s/he has been hospitalized for mental health or substance abuse reasons?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Within the last month	In the past 2 to 3 months	In the past 4 to 6 months	In the past 7 to 12 months	No hospitalization in the past year

11. Coping: How well do you feel your client is coping with his/her mental or emotional illness from day to day?

<input type="radio"/>				
Not well at all	Not very well	Alright	Well	Very well

12. Involvement with self-help activities: How involved is s/he in consumer run services, peer support groups, Alcoholics Anonymous, drop-in centers, WRAP (Wellness Recovery Action Plan), or other similar self-help programs?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Doesn't know about any self-help activities	Knows about some self-help activities, but isn't interested	Is interested in self-help activities, but hasn't participated in the past year	Participates in self-help activities occasionally	Participates in self-help activities regularly

13. Using Medication Effectively: (Don't answer this question if his/her doctor has not prescribed medication). How often does s/he take his/her medication as prescribed?

<input type="radio"/>				
Never	Occasionally	About half the time	Most of the time	Every day

\_\_\_ Check here if the client is not prescribed psychiatric medications.

14. Impairment of functioning through alcohol use: Drinking can interfere with functioning when it contributes to conflict in relationships, or to financial, housing and legal concerns, to difficulty showing up at appointments or focusing during them, or to increases of symptoms. Over the past 3 months, did alcohol use get in the way of his/her functioning?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol use really gets his/her way a lot	Alcohol use gets in his/her way quite a bit	Alcohol use gets in his/her way somewhat	Alcohol use gets in his/her way very little	Alcohol use is not a factor in his/her functioning

15. Impairment of functioning through drug use: Using street drugs, and misusing prescription or over-the-counter medication can interfere with functioning when it contributes to conflict in relationships, or to financial, housing and legal concerns, to difficulty showing up at appointments or focusing during them, or to increases of symptoms. Over the past 3 months, did drug use get in the way of his/her functioning?

<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drug use really gets in his/her way a lot	Drug use gets in his/her way quite a bit	Drug use gets in his/her way somewhat	Drug use gets in his/her way very little	Drug use is not a factor in his/her functioning

**Please complete the following items if the client is being seen for his/her follow-up treatment planning.**

Since the last formal treatment plan update of six months ago...	Yes	No	N/A (no goal on client's plan)
16. has the client demonstrated progress towards achieving his/her <b>employment goal</b> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. has the client demonstrated progress towards achieving his/her <b>housing goal</b> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. has the client demonstrated progress towards achieving his/her <b>education goal</b> ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

NOTE: Complete at Intake and 6 Month Treatment Plan Update

This form can be entered into HOMS at <https://homs.ucsd.edu> or faxed confidentially to (858) 622-1795.

**COMPLETED BY:**

1. Case Manager
2. Licensed/Waivered Psychologist
3. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
4. Licensed/Registered Professional Clinical Counselor
5. Physician (MD or DO)
6. Nurse Practitioner

**COMPLIANCE REQUIREMENTS:**

1. Completed for all clients open to identified unit/subunit for the following programs:
  - a. Case Management
  - b. ACT
  - c. FSP
2. Completed:
  - a. Upon admission to the program (within the initial 30 days of treatment open)
  - b. Annually from date of admission into program
  - c. At discharge from the program.

**DOCUMENTATION STANDARDS:**

1. This is a hand-written assessment and should be kept in the hybrid chart.
2. All elements should be completed.

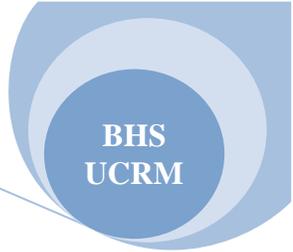
## LOCUS WORKSHEET VERSION 2010

Rater Name \_\_\_\_\_ Date \_\_\_\_\_

Please check the applicable ratings within each dimension and record the score in the lower right hand corner. Total your score and determine the recommended level of care using either the Placement Grid or the Decision Tree.

<p><b>I. Risk of Harm</b></p> <p><input type="checkbox"/> 1. Minimal Risk of Harm    Criteria _____</p> <p><input type="checkbox"/> 2. Low Risk of Harm    Criteria _____</p> <p><input type="checkbox"/> 3. Moderate Risk of Harm    Criteria _____</p> <p><input type="checkbox"/> 4. Serious Risk of Harm    Criteria _____</p> <p><input type="checkbox"/> 5. Extreme Risk of Harm    Criteria _____</p> <p style="text-align: right;">Score _____</p>	<p><b>IV-B. Recovery Environment - Level of Support</b></p> <p><input type="checkbox"/> 1. Highly Supportive Environment    Criteria _____</p> <p><input type="checkbox"/> 2. Supportive Environment    Criteria _____</p> <p><input type="checkbox"/> 3. Limited Support in Environment    Criteria _____</p> <p><input type="checkbox"/> 4. Minimal Support in Environment    Criteria _____</p> <p><input type="checkbox"/> 5. No Support in Environment    Criteria _____</p> <p style="text-align: right;">Score _____</p>
<p><b>II. Functional Status</b></p> <p><input type="checkbox"/> 1. Minimal Impairment    Criteria _____</p> <p><input type="checkbox"/> 2. Mild Impairment    Criteria _____</p> <p><input type="checkbox"/> 3. Moderate Impairment    Criteria _____</p> <p><input type="checkbox"/> 4. Serious Impairment    Criteria _____</p> <p><input type="checkbox"/> 5. Severe Impairment    Criteria _____</p> <p style="text-align: right;">Score _____</p>	<p><b>V. Treatment and Recovery History</b></p> <p><input type="checkbox"/> 1. Full Response to Treatment and Recovery Management Criteria _____</p> <p><input type="checkbox"/> 2. Significant Response to Treatment and Recovery Management Criteria _____</p> <p><input type="checkbox"/> 3. Moderate or Equivocal Response to Treatment and Recovery Management Criteria _____</p> <p><input type="checkbox"/> 4. Poor Response to Treatment and Recovery Management Criteria _____</p> <p><input type="checkbox"/> 5. Negligible Response to Treatment Criteria _____</p> <p style="text-align: right;">Score _____</p>
<p><b>III. Co-Morbidity</b></p> <p><input type="checkbox"/> 1. No Co-Morbidity    Criteria _____</p> <p><input type="checkbox"/> 2. Minor Co-Morbidity    Criteria _____</p> <p><input type="checkbox"/> 3. Significant Co-Morbidity    Criteria _____</p> <p><input type="checkbox"/> 4. Major Co-Morbidity    Criteria _____</p> <p><input type="checkbox"/> 5. Severe Co-Morbidity    Criteria _____</p> <p style="text-align: right;">Score _____</p>	<p><b>VI. Engagement</b></p> <p><input type="checkbox"/> 1. Optimal Engagement    Criteria _____</p> <p><input type="checkbox"/> 2. Positive Engagement    Criteria _____</p> <p><input type="checkbox"/> 3. Limited Engagement    Criteria _____</p> <p><input type="checkbox"/> 4. Minimal Engagement    Criteria _____</p> <p><input type="checkbox"/> 5. Unengaged    Criteria _____</p> <p style="text-align: right;">Score _____</p>
<p><b>IV-A. Recovery Environment - Level of Stress</b></p> <p><input type="checkbox"/> 1. Low Stress Environment    Criteria _____</p> <p><input type="checkbox"/> 2. Mildly Stressful Environment    Criteria _____</p> <p><input type="checkbox"/> 3. Moderately Stressful Environment    Criteria _____</p> <p><input type="checkbox"/> 4. Highly Stressful Environment    Criteria _____</p> <p><input type="checkbox"/> 5. Extremely Stressful Environment    Criteria _____</p> <p style="text-align: right;">Score _____</p>	<p><b>Composite Score</b></p> <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 150px;"></div> <p><b>Level of Care Recommendation</b></p> <div style="border: 1px solid black; width: 100px; height: 20px; margin-left: 150px;"></div>

# Milestones of Recovery Scale (MORS)

The logo for BHS UCRM is located in the top right corner. It consists of three concentric circles in shades of blue, with the text "BHS" above "UCRM" in white, centered within the innermost circle.

BHS  
UCRM

## **COMPLETED BY:**

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Nurse Practitioner

## **COMPLIANCE REQUIREMENTS:**

1. Completed by Outpatient program only
2. Completed at:
  - a. Assessment (within the initial 30 days of intake into the program).
  - b. Every 6 months after admission date.
  - c. Discharge from the program (within 7 days of closing assignment).

## **DOCUMENTATION STANDARDS:**

1. These forms are completed by hand.
2. All elements should be completed.
3. Used to assess clinicians perception of a client's current degree of recovery
4. Ratings are determined by 3 factors:
  - a. Client's level of risk
  - b. Client's level of engagement within the mental health system
  - c. Client's level of skills and support.

## Milestones of Recovery Scale (MORS)

Date:  Client Case #  Staff ID #

Unit  Subunit

Please select the number that best describes the current (typical for the last two weeks) milestone of recovery for the client listed above. If you have not had any contact (face-to-face or phone) with the client in the last two weeks, do not attempt to rate the client.

- 1. Extreme risk
- 2. High risk/not engaged
- 3. High risk/engaged
- 4. Poorly coping/not engaged
- 5. Poorly coping/engaged
- 6. Coping/rehabilitating
- 7. Early Recovery
- 8. Advanced Recovery

- 1. Extreme risk – These individuals are frequently and recurrently dangerous to themselves or others for prolonged periods. They are frequently taken to hospitals and/or jails or are institutionalized in the state hospital or an IMD. They are unable to function well enough to meet their basic needs even with assistance. It is extremely unlikely that they can be served safely in the community.
- 2. High risk/not engaged- These individuals often are disruptive and are often taken to hospitals and/or jails. They usually have high symptom distress. They are often homeless and may be actively abusing drugs or alcohol and experiencing negative consequences from it. They may have a serious co-occurring medical condition (e.g., HIV, diabetes) or other disability which they are not actively managing. They often engage in high-risk behaviors (e.g., unsafe sex, sharing needles, wandering the streets at night, exchanging sex for drugs or money, fighting, selling drugs, stealing, etc.). They may not believe they have a mental illness and tend to refuse psychiatric medications. They experience great difficulty making their way in the world and are not self-supportive in any way. They are not participating voluntarily in ongoing mental health treatment or are very uncooperative toward mental health providers.
- 3. High risk/engaged – These individuals differ from group 2 only in that they are participating voluntarily and cooperating in ongoing mental health treatment. They are still experiencing high distress and disruption and are low functioning and not self-supportive in any way.
- 4. Poorly coping/not engaged – These individuals are not disruptive. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or

jails. They may have moderate to high symptom distress. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They may not think they have a mental illness and are unlikely to be taking psychiatric medications. They may have deficits in several activities of daily living and need a great deal of support. They are not participating voluntarily in ongoing mental health treatment and/or are very uncooperative toward mental health providers.

- 5. Poorly coping/engaged – These individuals differ from group 4 only in that they are voluntarily participating and cooperating in ongoing mental health treatment. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They are not functioning well and require a great deal of support.
- 6. Coping/rehabilitating – These individuals are abstinent or have minimal impairment from drugs or alcohol. They are rarely being taken to hospitals and almost never being taken to jail. They are managing their symptom distress usually, though not always, through medication. They are actively setting and pursuing some quality of life goals and have begun the process of establishing non-disabled roles. They often need substantial support and guidance but they aren't necessarily compliant with mental health providers. They may be productive in some meaningful roles, but they are not necessarily working or going to school. They may be testing the employment or education waters, but this group also includes individuals who have retired. That is, currently they express little desire to take on (and may actively resist) the increased responsibilities of work or school, but they are more or less content and satisfied with their lives.
- 7. Early Recovery – These individuals are actively managing their mental health treatment to the extent that mental health staff rarely need to anticipate or respond to problems with them. Like group 6, they are rarely using hospitals and are not being taken to jails. Like group 6, they are abstinent or have minimal impairment from drugs or alcohol and they are managing their symptom distress. With minimal support from staff, they are setting, pursuing and achieving many quality of life goals (e.g., work and education) and have established roles in the greater (non-disabled) community. They are actively managing any physical health disabilities or disorders they may have (e.g., HIV, diabetes). They are functioning in many life areas and are very self-supporting or productive in meaningful roles. They usually have a well-defined social support network including friends and/or family.
- 8. Advanced Recovery – These individuals differ from group 7 in that they are completely self-supporting. If they are receiving any public benefits, they are generally restricted to Medicaid or some other form of health benefits or health insurance because their employer does not provide health insurance. While they may still identify themselves as having a mental illness, they are no longer psychiatrically disabled. They are basically indistinguishable from their non-disabled neighbor.

# Recovery Markers Questionnaire (RMQ)

DATE 

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 CLIENT CASE 

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STAFF ID# 

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 UNIT/SUB-UNIT# 

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به شدت مخالف	مخالف	بی طرف	موافق	به شدت موافق	برای هر کدام از پرسشهای زیر، لطفا پاسخی را که در مورد شما درست است پُر کنید.
<input type="radio"/>	وضعیت زندگی ام مطمئن است و احساس می کنم در خانه هستم.				
<input type="radio"/>	من به افرادی اعتماد کرده ام که می توانم برای کمک به آنها رجوع کنم.				
<input type="radio"/>	من حداقل یک رابطه متقابل نزدیک (دادن و گرفتن) دارم.				
<input type="radio"/>	من در فعالیتهای هدف دار سودمند مشارکت دارم.				
<input type="radio"/>	علائم روانپزشکی من تحت کنترل هستند.				
<input type="radio"/>	من درآمد کافی برای رفع نیازهایم دارم.				
<input type="radio"/>	من کار نمی کنم ولی فکر می کنم در عرض 6 ماه کار خواهم کرد.				
<input type="radio"/>	من چیزهای تازه ای یاد می گیرم که برایم مهم هستند.				
<input type="radio"/>	من در وضعیت سلامت جسمی خوب هستم.				
<input type="radio"/>	من یک زندگی/ارتباط معنوی مثبت با یک نیروی بالاتر دارم.				
<input type="radio"/>	من خودم را دوست داشته و به آن احترام می گذارم.				
<input type="radio"/>	من از نیروها، مهارتها و استعدادهای شخصی ام استفاده می کنم.				
<input type="radio"/>	من اهدافی دارم که تلاش می کنم به آنها برسم.				
<input type="radio"/>	من دلایلی دارم که صبحها زود از تختخواب بلند شوم.				
<input type="radio"/>	روزهای خوب من بیشتر از روزهای بد است.				
<input type="radio"/>	من یک کیفیت زندگی مناسب دارم.				
<input type="radio"/>	من تصمیمات مهم را در زندگی ام کنترل می کنم.				
<input type="radio"/>	من به جامعه ام کمک می کنم.				
<input type="radio"/>	من به عنوان یک شخص در حال رشد هستم.				
<input type="radio"/>	من یک حس تعلق دارم.				
<input type="radio"/>	من حس هشیاری و زنده بودن دارم.				
<input type="radio"/>	من درباره آینده ام امیدوار هستم.				
<input type="radio"/>	من می توانم از عهده استرس بر بیایم.				
<input type="radio"/>	من معتقدم می توانم در زندگی ام تغییرات مثبت ایجاد کنم.				
<input type="radio"/>	پس از آغاز خدمات اینجا، علائم من مرا کمتر ناراحت می کنند				
<input type="radio"/>	پس از آغاز خدمات در اینجا، با مسائل روزانه موثرتر برخورد می کنم				

بله	خیر	
<input type="radio"/>	<input type="radio"/>	من بصورت پاره وقت کار میکنم (کمتر از 35 ساعت در هفته)
<input type="radio"/>	<input type="radio"/>	من بصورت تمام وقت کار میکنم (35 ساعت یا بیشتر در هفته)
<input type="radio"/>	<input type="radio"/>	من در مدرسه هستم
<input type="radio"/>	<input type="radio"/>	من کار داوطلبانه می کنم
<input type="radio"/>	<input type="radio"/>	من در یک برنامه آموزش شغلی هستم
<input type="radio"/>	<input type="radio"/>	من در جستجوی اشتغال هستم
<input type="radio"/>	<input type="radio"/>	من بازنشسته هستم
<input type="radio"/>	<input type="radio"/>	من مرتب به یک باشگاه یا برنامه حمایت از همونوع می روم

مشارکت شما در فرایند بهبود: کدام یک از عبارات زیر درباره شما درست ترین است؟

<input type="radio"/>	من هرگز درباره رهایی از ناتوانی روانی نشنیده ام یا به آن فکر نکرده ام
<input type="radio"/>	من باور ندارم که احتیاج دارم از مشکلات روانی رها شوم
<input type="radio"/>	من وقت نداشته ام که واقعا به بهبود فکر کنم
<input type="radio"/>	من درباره بهبود فکر کرده ام ولی هنوز تصمیم نگرفته ام
<input type="radio"/>	من به بهبود خودم متعهد هستم و در حال برنامه ریزی هستم که خیلی زود اقدام کنم
<input type="radio"/>	من بصورت فعال در فرایند رهایی از ناتوانی روانی مشارکت دارم
<input type="radio"/>	من بصورت فعال در حال حرکت بسوی بهبود بودم ولی اکنون نیستم چون:
<input type="radio"/>	احساس می کنم بهبود یافته ام؛ فقط باید پیشرفتهای خودم را حفظ کنم
<input type="radio"/>	سایر (مشخص کنید): _____

Client could not complete because:  language  refused  unable  other (please specify): \_\_\_\_\_

NOTE: This form can be faxed confidentially to (858) 622-1795 with cover page.

# Recovery Markers Questionnaire (RMQ)

DATE 

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CLIENT CASE 

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STAFF ID# 

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UNIT/SUB-UNIT# 

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به شدت مخالف	مخالف	بی طرف	موافق	به شدت موافق	برای هر کدام از پرسشهای زیر، لطفا پاسخی را که در مورد شما درست است پُر کنید.
<input type="radio"/>	وضعیت زندگی ام مطمئن است و احساس می کنم در خانه هستم.				
<input type="radio"/>	من به افرادی اعتماد کرده ام که می توانم برای کمک به آنها رجوع کنم.				
<input type="radio"/>	من حداقل یک رابطه متقابل نزدیک (دادن و گرفتن) دارم.				
<input type="radio"/>	من در فعالیتهای هدف دار سودمند مشارکت دارم.				
<input type="radio"/>	علائم روانپزشکی من تحت کنترل هستند.				
<input type="radio"/>	من درآمد کافی برای رفع نیازهایم دارم.				
<input type="radio"/>	من کار نمی کنم ولی فکر می کنم در عرض 6 ماه کار خواهم کرد.				
<input type="radio"/>	من چیزهای تازه ای یاد می گیرم که برایم مهم هستند.				
<input type="radio"/>	من در وضعیت سلامت جسمی خوب هستم.				
<input type="radio"/>	من یک زندگی/ارتباط معنوی مثبت با یک نیروی بالاتر دارم.				
<input type="radio"/>	من خودم را دوست داشته و به آن احترام می گذارم.				
<input type="radio"/>	من از نیروها، مهارتها و استعدادهای شخصی ام استفاده می کنم.				
<input type="radio"/>	من اهدافی دارم که تلاش می کنم به آنها برسم.				
<input type="radio"/>	من دلایلی دارم که صبحها زود از تختخواب بلند شوم.				
<input type="radio"/>	روزهای خوب من بیشتر از روزهای بد است.				
<input type="radio"/>	من یک کیفیت زندگی مناسب دارم.				
<input type="radio"/>	من تصمیمات مهم را در زندگی ام کنترل می کنم.				
<input type="radio"/>	من به جامعه ام کمک می کنم.				
<input type="radio"/>	من به عنوان یک شخص در حال رشد هستم.				
<input type="radio"/>	من یک حس تعلق دارم.				
<input type="radio"/>	من حس هشیاری و زنده بودن دارم.				
<input type="radio"/>	من درباره آینده ام امیدوار هستم.				
<input type="radio"/>	من می توانم از عهده استرس بر بیایم.				
<input type="radio"/>	من معتقدم می توانم در زندگی ام تغییرات مثبت ایجاد کنم.				
<input type="radio"/>	پس از آغاز خدمات اینجا، علائم من مرا کمتر ناراحت می کنند				
<input type="radio"/>	پس از آغاز خدمات در اینجا، با مسائل روزانه موثرتر برخورد می کنم				

بله	خیر	
<input type="radio"/>	<input type="radio"/>	من بصورت پاره وقت کار میکنم (کمتر از 35 ساعت در هفته)
<input type="radio"/>	<input type="radio"/>	من بصورت تمام وقت کار میکنم (35 ساعت یا بیشتر در هفته)
<input type="radio"/>	<input type="radio"/>	من در مدرسه هستم
<input type="radio"/>	<input type="radio"/>	من کار داوطلبانه می کنم
<input type="radio"/>	<input type="radio"/>	من در یک برنامه آموزش شغلی هستم
<input type="radio"/>	<input type="radio"/>	من در جستجوی اشتغال هستم
<input type="radio"/>	<input type="radio"/>	من بازنشسته هستم
<input type="radio"/>	<input type="radio"/>	من مرتب به یک باشگاه یا برنامه حمایت از همونوع می روم

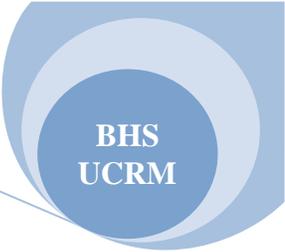
مشارکت شما در فرایند بهبود: کدام یک از عبارات زیر درباره شما درست ترین است؟

<input type="radio"/>	من هرگز درباره رهایی از ناتوانی روانی نشنیده ام یا به آن فکر نکردم
<input type="radio"/>	من باور ندارم که احتیاج دارم از مشکلات روانی رها شوم
<input type="radio"/>	من وقت نداشته ام که واقعا به بهبود فکر کنم
<input type="radio"/>	من درباره بهبود فکر کرده ام ولی هنوز تصمیم نگرفته ام
<input type="radio"/>	من به بهبود خود متعهد هستم و در حال برنامه ریزی هستم که خیلی زود اقدام کنم
<input type="radio"/>	من بصورت فعال در فرایند رهایی از ناتوانی روانی مشارکت دارم
<input type="radio"/>	من بصورت فعال در حال حرکت بسوی بهبود بدم ولی اکنون نیستم چون:
<input type="radio"/>	احساس می کنم بهبود یافته ام؛ فقط باید پیشرفتهای خودم را حفظ کنم
<input type="radio"/>	سایر (مشخص کنید): _____

Client could not complete because:  language  refused  unable  other (please specify): \_\_\_\_\_

NOTE: This form can be faxed confidentially to (858) 622-1795 with cover page.

# Recovery Markers Questionnaire (RMQ)

The logo for BHS UCRM is located in the top right corner. It consists of three concentric blue circles of varying shades, with the text "BHS" above "UCRM" centered within the innermost circle.

BHS  
UCRM

## **COMPLETED BY:**

1. Client
  - a. If client requires assistance staff can help with completion of the assessment. Ideally this would be done by a peer or volunteer but any staff can assist if needed.

## **COMPLIANCE REQUIREMENTS:**

1. Completed for all adults opened to Outpatient and Case Management Programs
2. Complete by:
  - a. Intake into the program (within the initial 30 days of open treatment session to program)
  - b. Every 6 months from date of intake
  - c. Discharge (within 7 days from the date of discharge to the program)
3. Results need to be entered into the following website:
  - a. <https://homs.ucsd.edu/login.aspx>

## **DOCUMENTATION STANDARDS:**

1. Used to assess personal recovery of the client from the perspective of the client.
2. Forms should be printed from website above and printed forms placed in the hybrid chart.
3. All elements should be completed.

# Recovery Markers Questionnaire (RMQ)

DATE: 

		/			/				

CLIENT CASE #: 

--	--	--	--	--	--	--	--	--	--

STAFF ID #: 

--	--	--	--	--	--	--	--	--	--

UNIT/SUB-UNIT: 

				/					
--	--	--	--	---	--	--	--	--	--

**For each of the following questions, please fill in the answer that is true for you now.**

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
My living situation is safe and feels like home to me.	<input type="radio"/>				
I have trusted people I can turn to for help.	<input type="radio"/>				
I have at least one close mutual (give-and-take) relationship.	<input type="radio"/>				
I am involved in meaningful productive activities.	<input type="radio"/>				
My psychiatric symptoms are under control.	<input type="radio"/>				
I have enough income to meet my needs.	<input type="radio"/>				
I am not working, but see myself working within 6 months.	<input type="radio"/>				
I am learning new things that are important to me.	<input type="radio"/>				
I am in good physical health.	<input type="radio"/>				
I have a positive spiritual life/connection to a higher power.	<input type="radio"/>				
I like and respect myself.	<input type="radio"/>				
I am using my personal strengths skills or talents.	<input type="radio"/>				
I have goals I'm working to achieve.	<input type="radio"/>				
I have reasons to get out of bed in the morning.	<input type="radio"/>				
I have more good days than bad.	<input type="radio"/>				
I have a decent quality of life.	<input type="radio"/>				
I control the important decisions in my life.	<input type="radio"/>				
I contribute to my community.	<input type="radio"/>				
I am growing as a person.	<input type="radio"/>				
I have a sense of belonging.	<input type="radio"/>				
I feel alert and alive.	<input type="radio"/>				
I feel hopeful about my future.	<input type="radio"/>				
I am able to deal with stress.	<input type="radio"/>				
I believe I can make positive changes in my life.	<input type="radio"/>				
My symptoms are bothering me less since starting services here	<input type="radio"/>				
I deal more effectively with daily problems since starting services here	<input type="radio"/>				

	Yes	No
I am working part time (less than 35 hours a week)	<input type="radio"/>	<input type="radio"/>
I am working full time (35 or more hours per week)	<input type="radio"/>	<input type="radio"/>
I am in school	<input type="radio"/>	<input type="radio"/>
I am volunteering	<input type="radio"/>	<input type="radio"/>
I am in a work training program	<input type="radio"/>	<input type="radio"/>
I am seeking employment	<input type="radio"/>	<input type="radio"/>
I am retired	<input type="radio"/>	<input type="radio"/>
I regularly visit a clubhouse or peer support program	<input type="radio"/>	<input type="radio"/>

**YOUR INVOLVEMENT IN THE RECOVERY PROCESS:** Which of the following statements is most true for you?

<input type="radio"/> I have never heard of, or thought about, recovery from psychiatric disability
<input type="radio"/> I do not believe I have any need to recover from psychiatric problems
<input type="radio"/> I have not had the time to really consider recovery
<input type="radio"/> I've been thinking about recovery, but haven't decided yet
<input type="radio"/> I am committed to my recovery, and am making plans to take action very soon
<input type="radio"/> I am actively involved in the process of recovery from psychiatric disability
<input type="radio"/> I was actively moving toward recovery, but now I'm not because: _____
<input type="radio"/> I feel that I am fully recovered; I just have to maintain my gains
<input type="radio"/> Other (specify): _____

Client could not complete because:  language  refused  unable  other (please specify): \_\_\_\_\_

NOTE: This form can be faxed confidentially to (858) 622-1795 with cover page.

© Priscilla A. Ridgway, 2005

**COMPLETED BY:**

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Nurse Practitioner
6. Case Manager

**COMPLIANCE REQUIREMENTS:**

1. Completed for client open to Outpatient clinics, Case Management and ACT programs, when client has an active substance related treatment plan goal in his/her client plan.
2. Completed at:
  - a. Admission into the program (within the initial 30 days of assignment open).
  - b. Every 6 months from date of admission into the program, as long as client continued to have a substance related goal in his/her client plan.

**DOCUMENTATION STANDARDS:**

1. Assessment is hand written and filed in the hybrid chart.
2. All elements should be completed.

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## Substance Abuse Treatment Scale - Revised (SATS-R)

From *Integrated Treatment for Dual Disorders* by Kim T. Mueser, Douglas L. Noordsy, Robert E. Drake, and Lindy Fox. Copyright 2003 by The Guilford Press: New York.

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**Instructions:** This scale is for assessing a person's stage of substance abuse treatment, not for determining diagnosis. The reporting interval is 6 months. The clinician will document in a progress note what level was chosen and the justification for the choice. The clinician will provide the names, dates, and scores to the Program Manager monthly.

1. **Pre-engagement.** The person (not yet a client) does not have contact with a case manager, mental health counselor or substance abuse counselor, and meets criteria for substance abuse or dependence.
2. **Engagement** The client has had only irregular contact with an assigned case manager or counselor, and meets criteria for substance abuse or dependence.
3. **Early Persuasion.** The client has regular contacts with a case manager or counselor; continues to use the same amount of substances, or has reduced substance use for less than 2 weeks; and meets criteria for substance abuse or dependence.
4. **Late Persuasion.** The client has regular contacts with a case manager or counselor; shows evidence of reduction in use for the past 2-4 weeks (fewer drugs, smaller quantities, or both); but still meets criteria for substance abuse or dependence.
5. **Early Active Treatment.** The client is engaged in treatment and has reduced substance use for more than the past month, but still meets criteria for substance abuse or dependence during this period of reduction.
6. **Late Active Treatment.** The person is engaged in treatment, and has not met criteria for substance abuse or dependence for the past 1-5 months.
7. **Relapse Prevention.** The client is engaged in treatment, and has not met criteria for substance abuse or dependence for the past 6-12 months.
8. **In Remission or Recovery.** The client has not met criteria for substance abuse or dependence for more than the past year.

Initial Level: \_\_\_\_

Client Plan Update: \_\_\_\_

Client Plan Update: \_\_\_\_

Date\_\_\_\_\_

Date\_\_\_\_\_

Date\_\_\_\_\_

\_\_\_\_\_  
Clinician/Title

\_\_\_\_\_  
Clinician/Title

\_\_\_\_\_  
Clinician/Title

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County of San Diego  
Health and Human Services Agency  
Mental Health Services

SUBSTANCE ABUSE TREATMENT SCALE - REVISED  
July 1, 2005

**Client:** \_\_\_\_\_

**MR/Client ID #:** \_\_\_\_\_

**Program:** \_\_\_\_\_

County of San Diego Health and Human Services Agency (HHSA) Mental Health Services Policies and Procedures MHS General Administration			
Subject:	<b>Transition Age Youth Referral</b>	No:	<b>01-02-212</b> <b>Formerly: 01-01-114</b>
Reference:	<b>Mental Health (MH) Youth Transition Service Plan, July 2000</b>	Page:	1 of 3

**PURPOSE:**

To support system of care practice by establishing a process for the transition of clients from County and contracted Children’s Mental Health Services (CMHS) when routine referrals have been unsuccessful.

**POLICY:**

Provide a collaborative process between CMHS and Adult/Older Adult Mental Health (A/OAMH) Services when routine referrals have been unsuccessful to determine an appropriate referral disposition for youth in CMHS who are attaining 18 years (or older in some cases, i.e., AB2726) and who may need continued care in the A/OAMH System of Care.

**BACKGROUND:**

Youth receiving mental health services in the Children’s Mental Health System of Care and who are reaching 18 years of age may require system coordination to successfully transition to the Adult System of Care. To provide integrated services; the following procedure is established when routine referrals have been unsuccessful.

**PROCEDURE(S):**

1. Youth who need transition planning due to their unique needs but for whom routine referrals have been unsuccessful will be identified by the Children’s System of Care staff, either their Case Manager or Care Coordinator, who shall submit a referral packet containing the following information:
  - Referral Form/Cover Letter,
  - 650 Children’s Mental Health Assessment and most recent update,
  - Current Five Axis Diagnosis,
  - Youth Transition Evaluation,
  - Mental Status conducted by psychiatrist within the last 45 days,
  - Physical Health Information,
  - Medication Sheet,
  - Service Plan and other plans, e.g., Flexible Service Plan, Therapeutic Behavioral Services (TBS)Plan,
  - Psychological testing done within past year (if available),
  - Individual Education Plan and Individual Transition Plan,

Approved Date:	Approved:
1/25/10	Alfredo Aguirre’s Signature on File
	Director, Mental Health Services/Designee

County of San Diego  
Health and Human Services Agency (HHSA)  
Mental Health Services  
Policies and Procedures

MHS General Administration

Subject: **Transition Age Youth Referral**

No: **01-02-212**

Page: **2** of **3**

- Assessment of financial needs (may need referral to apply for Supplemental Security Income (SSI) six months prior to 18th birthday), and
  - Any self evaluations recently given to youth.
2. This packet shall be submitted with releases to the Mental Health Program Coordinator (MHPC) of Adult Mental Health Services in the region where youth resides. The MHPC offices are located at 3255 Camino del Rio South, San Diego, CA 92108.
  3. The MHPC will review the packet to determine medical necessity according to Title 9 and the Service Eligibility Policy for the Adult/Older Adult System of Care (to include AB2726 referrals).
  4. If the client does not meet medical necessity criteria (or AB2726 criteria), then the client shall be referred back to the referral source for services in the community. If the youth is 18 or over, an assessment will be requested from an adult provider agreeable to the client and family. If the assessment indicates a Medi-Cal beneficiary doesn't meet medical necessity criteria, a Notice of Action Assessment (NOA-A) will be issued, advising him/her of his/her rights to appeal the decision.
  5. If a transition plan is agreed upon, the client's CMHS Case Manager or Care Coordinator will attempt to link the client with the targeted service.
  6. If the linkage is not successful, the MHPC shall coordinate an initial meeting with a multidisciplinary team within **two weeks** of the initial referral that will include relevant persons that may include, but are not limited to, the following:
    - Youth,
    - Support System (parent, social worker, family members),
    - Children's Mental Health Case Manager and/or Therapist,
    - Current Psychiatrist,
    - Chief of Children's Outpatient Services (or designee),
    - MHPC
    - Adult/Older Adult Case Management Contracting Officer's Technical Representative (COTR) if applicable, or designee,
    - Probation Officer (if applicable), and
    - Educational/Vocational Specialist.
  7. Team will review services and options and create a transition plan, complete the Transition Age Youth Referral Plan form, including all signatures. The Care Coordinator will include a copy of the Transition Plan in the medical record. The plan shall identify the individual that will follow up with the transition plan. Should the youth decide this plan is not acceptable, an alternative shall be identified and same procedure followed.

**ATTACHMENT(S):**

A - [Transition Age Youth Referral Form](#)

B - [Transition Age Youth Referral Plan](#)

County of San Diego  
Health and Human Services Agency (HHSA)  
Mental Health Services  
Policies and Procedures

MHS General Administration

Subject: **Transition Age Youth Referral**

No: **01-02-212**

Page: **3** of **3**

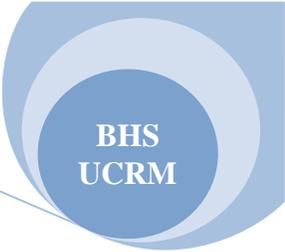
**SUNSET DATE:**

This policy will be reviewed for continuance on or before November 30, 2012.

**AUTHOR/CONTACT ON 11/23/09:**

Virginia West

# TRANSITIONAL YOUTH REFERRAL PLAN

The logo for BHS UCRM is located in the top right corner. It consists of three overlapping circles in shades of blue, with the text "BHS" above "UCRM" in white, centered within the circles.

BHS  
UCRM

## COMPLETED BY:

1. Staff providing services.

## COMPLIANCE REQUIREMENTS:

1. Completed for any client turning 18 years (or older) who is assessed by a current Children's Mental Health provider to be a candidate for Adult Mental Health Services.
2. Only complete this form when a direct referral to Adult Mental Health Services has not been successful.
3. This is a three part process:
  - a. **Section I** – completed by the referring Children's Mental Health provider
  - b. **Section II** – completed by the Regional Program Coordinator/Designee
  - c. **Section III** – Completed by Regional Program Coordinator /Designee only when the linkage is not successful

## DOCUMENTATION STANDARDS:

1. Complete when Children's Mental Health provider is unable to make a routine or successful referral to Adult Mental Health Services.
2. Use the Transitional Youth Referral Plan form (MHS-605) and file in the hybrid chart.

# TRANSITIONAL YOUTH REFERRAL PLAN

(SEE TRANSITIONAL AGE YOUTH REFERRAL POLICY AND PROCEDURE 01-01-114 FOR MORE DETAILS)

<b>Client:</b>	<b>InSyst #:</b>	<b>Program:</b>
----------------	------------------	-----------------

## Section I (completed by Children's program with attached referral packet and releases)

Staff Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Referring Program: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Email: \_\_\_\_\_

Client's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Client's Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Insurance Status: \_\_\_\_\_  
Current Diagnosis: \_\_\_\_\_  
Services currently receiving: \_\_\_\_\_  
Services needed from Adult Mental Health System of Care: \_\_\_\_\_

### I have attempted to refer to the following Adult Mental Health Programs unsuccessfully (include all attempts and outcome);

Program Name: \_\_\_\_\_  
Staff member contacted: \_\_\_\_\_  
Outcome (include reason for denial of admission and referrals given): \_\_\_\_\_

Program Name: \_\_\_\_\_  
Staff member contacted: \_\_\_\_\_  
Outcome (include reason for denial of admission and referrals given): \_\_\_\_\_

Other Comments: \_\_\_\_\_

**SECTION II** (completed by RPC / designee & provided to Children's provider who initiated request)

**Regional Program Coordinator's (RPC) Response:**

- deny services because client does not meet medical necessity criteria
- youth 18 and over; an assessment will be requested from an adult provider agreeable to the client and family (see specifics below)
- other (see specifics below)

Program referred to:  
Staff Name/Contact:  
Phone Number:                      Fax Number:

RPC / Designee's Name:                      Date:  
Phone Number:                      Fax Number:  
Email:

Date response was forwarded to referring party: \_\_\_\_\_

---

**SECTION III** (Completed by RPC when the linkage is not successful. RPC shall coordinate an initial meeting with a multidisciplinary team within two weeks of the initial referral.)

**Date of initial meeting:**

**Multidisciplinary Team Members Names and Signatures:**

**Transition Plan Recommendation:**

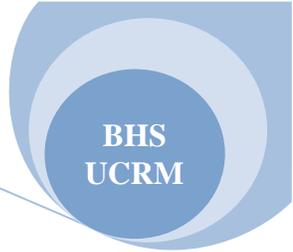
**Individual to follow up on Plan:**

Phone Number:                      Fax Number: \_\_\_\_\_  
Email:

Date copy of completed form sent to original children's referral source:

Youth accepted plan:  Yes  No  Other:  
(when "no" an alternative shall be identified & same procedure followed)

**UTILIZATION MANAGEMENT REQUEST AND AUTHORIZATION**  
**Outpatient Treatment & Case Management Programs**  
**Children's Programs Only**



**COMPLETED BY:**

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Nurse Practitioner/Physician Assistant
6. Registered Nurse\*
7. Licensed Psychiatric Technician/Vocational Nurse\*
8. Registered PsyD and Trainee\*

**COMPLIANCE REQUIREMENTS:**

1. For all outpatient and case management clients prior to expiration of the current UM Cycle, the program is expected to complete a UM Authorization.
2. UM Authorization Form must have all elements and narratives complete within the form.
3. When completing the entirety of the UM process the following elements are required:
  - a. UM Form
  - b. Updated CFARS in CCBH
  - c. Updated CAMS
  - d. The client plan must be reviewed and new client signatures need to be obtained
  - e. COR approval as necessary for the specific program
4. The UM representative completing the review prints name, signs, and dates the form.
5. A Title 9 Included Diagnosis must be included.

**DOCUMENTATION STANDARDS:**

1. Staff requesting services outline the date of initial admission in the program, type of services offered by program, current planned session frequency per month, number of additional sessions requested and any additional comments.
2. Retroactive authorization is not acceptable (the program must contact the COTR when a client has no UM in place to cover claims).
3. Staff requesting services identify all the proposed treatment modalities with the planned frequency. The expected outcome and prognosis follows. The requesting staff then outlines the actual requested number of treatment sessions to continue providing services.
4. Utilization Management is a non-billable activity. Therefore, there is no billing for preparation of the UM form or for the UM review time spent on the case. UM is an administrative function.

**UTILIZATION MANAGEMENT (UM) REQUEST AND AUTHORIZATION  
CYF - Outpatient Treatment**

Client Name:	Client #:                      Program:
<b>ADMISSION DATE:</b> <b>CURRENT SERVICES &amp; FREQUENCY:</b> <input type="checkbox"/> MHS <input type="checkbox"/> MHS-R <input type="checkbox"/> CM <input type="checkbox"/> Meds sessions per month <b>Does youth/family request additional services?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> Explain:	<b>DIAGNOSIS:</b>  <b>ICD-10 CODE(S):</b>  <b>DESCRIPTION:</b>

**Psychiatric Hospitalizations:** YES    NO  (*Provide relevant history*):

**Other Services Client Receiving:**

See CFARS dated:            at  Admission or  UM Cycle   **CURRENT CFARS Reviewed:**  YES    NO

**RATIONALE FOR ADDITIONAL SERVICES:**

COR approved UM Exception. For            session cycle OR            months cycle (*written exception on file*).

New Client Plan was completed prior to UM request and reviewed by UM Committee (*client/family input/signatures may be pending UM Approval*)

**ELIGIBILITY CRITERIA: UM POST INITIAL 13 SESSIONS**

Client continues to meet Medical Necessity and demonstrates benefit from services

- Consistent participation:  YES    NO
- CFARS – Impairment Rating guideline of 5:  YES    NO
- Client meets criteria for Pathways to Well-Being Enhanced Services:  YES    NO

Client meets the criteria for SED based upon the following:

As a result of a mental disorder the child has **substantial** and **persistent** impairment in at least two of the following areas:

- Self-care and self-regulation
- Family relationships
- Ability to function in the community
- School functioning

**AND One of the following occurs:**

- Child at risk for removal from home due to a mental disorder
- Child has been removed from home due to a mental disorder
- Mental disorder/impairment is severe and has been present for six months, or is highly likely to continue for more than one year without treatment.

**OR The child displays:**

- acute psychotic features,
- imminent risk for suicide
- imminent risk of violence to others due to a mental disorder

**ELIGIBILITY CRITERIA – UM POST 26 SESSIONS** (*Requires COR approval*)

Client has met the above criteria as indicated **AND Meets a minimum of one continuing current Risk Factor related to child's primary diagnosis:**

- Child has been a danger to self or other in the last two weeks
- Child experienced severe physical or sexual abuse or has been exposed to extreme violent behaviors in the home in the last two weeks

- Child's behaviors are so substantial and persistent that current living situation is in jeopardy
- Child exhibited bizarre behaviors in the last two weeks
- Child has experienced trauma within the last two weeks

<b>Proposed Treatment Modalities:</b> <input type="checkbox"/> Family Therapy <input type="checkbox"/> Group Therapy <input type="checkbox"/> Individual Therapy <input type="checkbox"/> Collateral Services <input type="checkbox"/> Case Management/Brokerage <input type="checkbox"/> Individual Rehab <input type="checkbox"/> Group Rehab <input type="checkbox"/> Medication Services	<b>Planned Frequency:</b> per month per month per month per month per month per month per month per month	<b>Expected Outcome and Prognosis:</b> <input type="checkbox"/> Return to full functioning <input type="checkbox"/> Expect improvement but less than full functioning <input type="checkbox"/> Relieve acute symptoms, return to baseline functioning <input type="checkbox"/> Maintain current status/prevent deterioration
<b>Pathways to Well-Being (Katie A. Subclass Only)</b> <input type="checkbox"/> Intensive Care Coordination per month <input type="checkbox"/> Intensive Home Based Services per month		

<b>REQUESTED NUMBER OF SESSIONS:</b>	<b>REQUESTED NUMBER OF MONTHS:</b> (for programs under written COR approval)
--------------------------------------	---

**PROGRAM REVIEW: ADDITIONAL UM CYCLE**

Requestor's Name, Credential & Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Request:**  Approved  Reduced  Denied Sessions/Time Approved: \_\_\_\_\_

Approver's Name, Credential & Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_

**COR REVIEW: UM POST 26 SESSIONS**

**Request:**  Approved  Reduced  Denied  Retroactive Authorization Sessions/Time Approved: \_\_\_\_\_

COR Name and Credentials: \_\_\_\_\_ Date Approved: \_\_\_\_\_

Comments: \_\_\_\_\_

(attach written COR approval; NOA-B may be required for Medi-Cal Clients)

يرجى أن تقوم بقراءة كافة البيانات الحياتية الواردة أدناه و قم بتحديد الإجابة التي تنطبق عليك:

الصحة البدنية/الصحة النفسية	كلا، بالإطلاق	نوعاً ما	نعم، بالتأكيد	لا ينطبق	
1. أعرف كيف يمكنني الحفاظ على خدمات الصحة النفسية التي أستحصل عليها، أو كيفية إستعادتها مرةً أخرى.	1	2	3	4	5
2. أعرف كيف يمكنني الحصول على نسخة من ملفي إن إحتجت إلى ذلك.	1	2	3	4	5
3. أعرف المشاكل التي أعاني منها، و أعرف كيف يمكنني أن أحصل على المساعدة.	1	2	3	4	5
4. أعرف كيف يمكنني أن أجد طبيباً أو معالجاً و كيف يمكنني أن أطلب موعداً.	1	2	3	4	5
5. أعرف أسماء الأدوية و العقاقير التي أتناولها.	1	2	3	4	5
6. أعرف و أستطيع أن أقول الأسباب التي تدفعني لتناول الأدوية و العقاقير.	1	2	3	4	5
7. أعرف كيف يمكنني الحصول على المزيد من الدواء أو العقار كي لا ينفذ.	1	2	3	4	5
8. أعرف كيف يمكنني الحصول على المساعدة إن كانت لدي مشاكل في تناول الكحول أو المخدرات.	1	2	3	4	5
9. أعرف تأثير تناول المخدرات أو الكحول أو التدخين على جسدي.	1	2	3	4	5
10. أعرف كيف أشرح الأعراض الجانبية للعقاقير و الأدوية التي أتناولها.	1	2	3	4	5
11. يظهر علي تحكم جيد بالنفس.	1	2	3	4	5
12. أعرف بعض الطرق التي تساعدني على التغلب على الضغط النفسي.	1	2	3	4	5
13. أعرف كيف يمكنني أن أتجنب الحمل أو الإصابة بالأمراض المنتقلة عن طريق الجنس.	1	2	3	4	5
الإجراءات و التعليقات:					

القدرات الإجتماعية	كلا، بالإطلاق	نوعاً ما	نعم، بالتأكيد	لا ينطبق	
1. خلال وقت فراغي، أجد شيئاً أقوم به لا يسبب لي المشاكل.	1	2	3	4	5
2. لدي نشاطات إيجابية في وقت فراغي أستمتع بالقيام بها.	1	2	3	4	5
3. أشارك بالفعاليات و الأنشطة الجماعية (الرياضة، المجموعات الشبابية، الخ).	1	2	3	4	5
4. أستطيع أن أشرح أحاسيسي.	1	2	3	4	5
5. أستطيع أن أتعامل مع الأمور التي تغضبني من دون صراخ أو ضرب أو تكسير.	1	2	3	4	5
6. أتحدث عن مشاكلي مع عائلتي و أصدقائي.	1	2	3	4	5
7. أرغب بأن يقوم كل من عائلتي و أصدقائي بمساعدتي.	1	2	3	4	5
8. لدي أصدقاء من نفس عمري.	1	2	3	4	5
9. أعرف كيف أكون مؤدباً في التعامل مع الآخرين.	1	2	3	4	5
10. أستطيع أن أقدم (أعرف) نفسي لأشخاص لم ألتقيهم من قبل.	1	2	3	4	5
11. أعرف كيف أكون مستمعاً جيداً، و كيف أقوم بطرح الأسئلة عندما أحتاج لفهم شيء ما بشكل أفضل.	1	2	3	4	5
12. أعرف بعض الطرق التي تجعلني أساعد بها الآخرين الذي يعيشون بقربي.	1	2	3	4	5
13. أستطيع أن أشرح خلفيتي الثقافية.	1	2	3	4	5
الإجراءات و التعليقات:					

County of San Diego - CMHS

Client: \_\_\_\_\_

InSyst #: \_\_\_\_\_

Program: \_\_\_\_\_

مهارات الحياة اليومية	كلا، بالإطلاق	نوعاً ما	نعم، بالتأكيد	لا ينطبق	
1. أعرف بمن يجب عليّ الإتصال في الحالات الطارئة.	1	2	3	4	5
2. أحافظ على نظافة أسناني و جسدي.	1	2	3	4	5
3. أعرف كيف أقوم بغسل ملابسي.	1	2	3	4	5
4. أحافظ على غرفة نومي نظيفة.	1	2	3	4	5
5. أعرف كيف أشتري الأشياء من محلات البقالة و المتاجر.	1	2	3	4	5
6. أعرف كيف أحضر طعامي.	1	2	3	4	5
7. أعرف أنواع الطعام التي يجب عليّ تناولها للحفاظ على صحتي.	1	2	3	4	5
8. أعرف كيف يمكنني الحصول على إجازة قيادة المركبات في كاليفورنيا أو على هوية إثبات الشخصية.	1	2	3	4	5
9. أعرف كيف أستخدم حافلة نقل الركاب (الباص) و وسائل النقل العامة الأخرى.	1	2	3	4	5
10. أستطيع أن أدل شخص آخر على محل سكني.	1	2	3	4	5
11. أستطيع أن أعني بنفسي إن كنت مريضاً أو مصاباً كما و أعرف أين يمكنني الحصول على المساعدة.	1	2	3	4	5
12. أعرف كيف يمكنني إصلاح الأشياء في المنزل إن تعطلت.	1	2	3	4	5
13. أعرف ما هي الأشياء التي قد تكون خطيرة في المنزل و أعرف كيف أقوم بتجنب خطرها.	1	2	3	4	5
14. أعرف كيف يمكنني أن أجد مكان لأسكن فيه.	1	2	3	4	5
الإجراءات و التعليقات:					

الشؤون المالية	كلا، بالإطلاق	نوعاً ما	نعم، بالتأكيد	لا ينطبق	
1. أعرف كيف أدير أموالي و أستطيع أن أقوم بدفع فواتيري بإستمرار و إنتظام.	1	2	3	4	5
2. أعرف كيف أقوم بكتابة صك (شيك) و أعرف كيف أستعمل بطاقات الإئتمان و البطاقات المصرفية، كما إنني أعرف كيف أقوم بالدفع نقداً و الحصول على باقي الحساب بشكل مضبوط.	1	2	3	4	5
3. أعرف كيف أقرر أن أشتري شيئاً ما قبل الأشياء الأخرى إن كنت أحتاج لعدة أشياء و لا أملك المال الكافي لشرائها جميعاً.	1	2	3	4	5
4. أستطيع أن أشرح إيجابيات و سلبيات إستخدام بطاقات الإئتمان.	1	2	3	4	5
الإجراءات و التعليقات:					

التعليم و التدريب المهني	كلا، بالإطلاق	نوعاً ما	نعم، بالتأكيد	لا ينطبق	
1. أعرف مالذي يمكن أن يساعدني على تعلم أشياء جديدة.	1	2	3	4	5
2. أعرف مالذي أحب القيام به.	1	2	3	4	5
3. أعرف الأشياء التي أجد القيام بها.	1	2	3	4	5
4. أعرف ما هي أهدافي الدراسية.	1	2	3	4	5
5. أعرف كيف أحقق أهدافي الدراسية.	1	2	3	4	5
6. أعرف ما هي المهنة التي أرغب بالقيام بها.	1	2	3	4	5
7. أستطيع أن أشرح إحتياجات دراستي أو تدريبي المهني من أجل المهنة التي أرغب بالقيام بها.	1	2	3	4	5
8. أستطيع أن أعرف ما هي النشاطات و الدروس التي تقدمها مؤسسة ما.	1	2	3	4	5
9. أعرف أن الحضور للعمل في موعده أمر ضروري و أستطيع القيام بذلك.	1	2	3	4	5
10. إنهي واجبات عملي في موعدها.	1	2	3	4	5
11. أتبع توجيهات مديري في العمل أو مدرسي.	1	2	3	4	5
الإجراءات و التعليقات:					

**STAFF TO SEE INSTRUCTIONS REGARDING ITEMS THAT MUST BE ADDRESSED.**

County of San Diego - CMHS

Client: \_\_\_\_\_

InSyst #: \_\_\_\_\_

Program: \_\_\_\_\_

YOUTH TRANSITION SELF-EVALUATION

Please read each of the following LIFE DOMAIN statements and circle the answer that sounds the most like you:

<b>HEALTH/MENTAL HEALTH</b>	<b>No, Not at All</b>		<b>Somewhat</b>		<b>Yes, Definitely</b>	<b>N/A</b>
1. I know how to keep my mental health services, or get them going again.	1	2	3	4	5	N/A
2. I know how to get a copy of my file if I need one.	1	2	3	4	5	N/A
3. I know what problems I have and how to get the help I need.	1	2	3	4	5	N/A
4. I know how to find a therapist or doctor and how to make an appointment.	1	2	3	4	5	N/A
5. I know the names of the medicines I take.	1	2	3	4	5	N/A
6. I know and can say why I take the medicines.	1	2	3	4	5	N/A
7. I know how to get more of my medicine so I don't run out.	1	2	3	4	5	N/A
8. I know how to get help if I have a problem with drugs or alcohol.	1	2	3	4	5	N/A
9. I know what taking illegal drugs, alcohol or smoking can do to my body.	1	2	3	4	5	N/A
10. I can explain the side effects my medicines can cause.	1	2	3	4	5	N/A
11. I show appropriate self-control.	1	2	3	4	5	N/A
12. I know some things I can do to deal with stress.	1	2	3	4	5	N/A
13. I know how I can prevent pregnancy & sexually transmitted diseases.	1	2	3	4	5	N/A
<b>ACTIONS/COMMENTS:</b> _____						
_____						

<b>SOCIAL SKILLS</b>	<b>No, Not at All</b>		<b>Somewhat</b>		<b>Yes, Definitely</b>	<b>N/A</b>
1. During my free time, I find something to do that doesn't get me into trouble.	1	2	3	4	5	N/A
2. I have positive free time activities that I enjoy.	1	2	3	4	5	N/A
3. I am involved in group activity (sports, youth group, etc.).	1	2	3	4	5	N/A
4. I can explain how I am feeling.	1	2	3	4	5	N/A
5. I can handle things that make me mad without yelling, hitting, or breaking things.	1	2	3	4	5	N/A
6. I talk over problems with friends/family.	1	2	3	4	5	N/A
7. I am willing to have my family or friends help me.	1	2	3	4	5	N/A
8. I have friends my own age.	1	2	3	4	5	N/A
9. I know how to be polite to others.	1	2	3	4	5	N/A
10. I am able to introduce myself to new people.	1	2	3	4	5	N/A
11. I know how to be a good listener, and ask questions when I need to understand better.	1	2	3	4	5	N/A
12. I know some ways I could help others who live near me.	1	2	3	4	5	N/A
13. I can explain my own cultural background.	1	2	3	4	5	N/A
<b>ACTIONS/COMMENTS:</b> _____						
_____						

County of San Diego - CMHS

Client: \_\_\_\_\_

InSyst #: \_\_\_\_\_

Program: \_\_\_\_\_

YOUTH TRANSITION SELF-EVALUATION

<b>DAILY LIVING SKILLS</b>	<b>No, Not at All</b>		<b>Somewhat</b>		<b>Yes, Definitely</b>	<b>N/A</b>
1. I know who to call if there is an emergency.	1	2	3	4	5	N/A
2. I keep my teeth and body clean.	1	2	3	4	5	N/A
3. I know how to do my own laundry.	1	2	3	4	5	N/A
4. I keep my room clean.	1	2	3	4	5	N/A
5. I know how to buy things at the grocery store.	1	2	3	4	5	N/A
6. I know how to cook my own meals.	1	2	3	4	5	N/A
7. I know what foods I should eat to keep me healthy.	1	2	3	4	5	N/A
8. I know how to get a driver's license or California I.D.	1	2	3	4	5	N/A
9. I know how to use buses or other public transportation.	1	2	3	4	5	N/A
10. I can give somebody directions to where I live.	1	2	3	4	5	N/A
11. I can take care of myself if I am sick or get hurt, and I know where to get help.	1	2	3	4	5	N/A
12. I know how to get something fixed at home if it is broken.	1	2	3	4	5	N/A
13. I know what could be unsafe in my home and how to fix it.	1	2	3	4	5	N/A
14. I know how to find a place to live.	1	2	3	4	5	N/A
<b>ACTIONS/COMMENTS:</b> _____						

<b>FINANCIAL</b>	<b>No, Not at All</b>		<b>Somewhat</b>		<b>Yes, Definitely</b>	<b>N/A</b>
1. I know how to manage my money so I can always pay my bills.	1	2	3	4	5	N/A
2. I know how to write a check, use a credit card or a debit card, and I know how to pay by cash and get the right change back.	1	2	3	4	5	N/A
3. I know how to decide what to buy first if I want several things and don't have enough money for everything.	1	2	3	4	5	N/A
4. I can explain the good & bad points of buying on credit.	1	2	3	4	5	N/A
<b>ACTIONS/COMMENTS:</b> _____						

<b>EDUCATIONAL/VOCATIONAL</b>	<b>No, Not at All</b>		<b>Somewhat</b>		<b>Yes, Definitely</b>	<b>N/A</b>
1. I know what helps me learn new things.	1	2	3	4	5	N/A
2. I know what I like to do.	1	2	3	4	5	N/A
3. I know what I am good at doing.	1	2	3	4	5	N/A
4. I know what my educational goals are.	1	2	3	4	5	N/A
5. I know how to meet my educational goals.	1	2	3	4	5	N/A
6. I know what kind of job or career I would like to have.	1	2	3	4	5	N/A
7. I can explain the education and/or training needed for my career options.	1	2	3	4	5	N/A
8. I can find out what kinds of activities/classes an organization offers.	1	2	3	4	5	N/A
9. I know coming to work on time every day is very important, and I can do it.	1	2	3	4	5	N/A
10. I get my work done on time.	1	2	3	4	5	N/A
11. I follow directions from my supervisor/teacher.	1	2	3	4	5	N/A
<b>ACTIONS/COMMENTS:</b> _____						

**STAFF TO SEE INSTRUCTIONS REGARDING ITEMS THAT MUST BE ADDRESSED.**

County of San Diego - CMHS

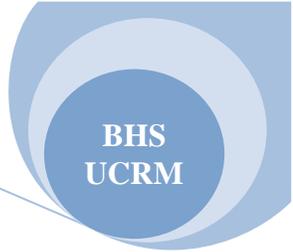
**Client:** \_\_\_\_\_

**InSyst #:** \_\_\_\_\_

**Program:** \_\_\_\_\_

**YOUTH TRANSITION SELF-EVALUATION**

# YOUTH TRANSITION SELF-EVALUATION

The logo for BHS UCRM is located in the top right corner. It consists of three concentric circles in shades of blue, with the text "BHS" above "UCRM" in the center.

BHS  
UCRM

## **COMPLETED BY:**

1. Client
2. Staff may offer assistance should the client need assistance.

## **COMPLIANCE REQUIREMENTS**

1. All prompts should be completed.
2. The following five life domains are rated by circling a 1-5 or non-applicable:
  - a. Health/Mental Health
  - b. Social Skills
  - c. Daily Living Skills
  - d. Financial
  - e. Educational/Vocational
3. Staff must address any item/s that result in a score of less than 3 by a written comment in the "Action" section of the form.

## **DOCUMENTATION STANDARDS:**

1. **OPTIONAL:** For clients 16 years or older, within 30 calendar days of opening the client to the program. When client has been in the System of Care, the evaluation form should be requested from the prior provider. If the evaluation is not received prior to the thirty days, a new evaluation shall be completed.
2. The evaluation form must be updated at age 17, 17 1/2, 18 and yearly thereafter until client is discharged from Children's Mental Health System of Care.
3. Youth Transition Self-Evaluation form (MHS-624) and filed in the hybrid chart.

**Por favor lea cada una de las siguientes afirmaciones sobre los diferentes ASPECTOS DE LA VIDA y marque con un círculo la respuesta que le parezca más cercana a lo que usted sabe o hace:**

<b>SALUD FÍSICA / MENTAL</b>	<b>No, no sé</b>	<b>Sé un poco</b>			<b>Sí, sí sé</b>	<b>N/A</b>
1. Sé cómo conservar mis servicios de salud mental o cómo reactivarlos.	1	2	3	4	5	N/A
2. Sé cómo obtener una copia de mi expediente si lo necesito.	1	2	3	4	5	N/A
3. Sé los problemas que tengo y cómo conseguir la ayuda que necesito.	1	2	3	4	5	N/A
4. Sé cómo buscar a un terapeuta o a un médico y sé como hacer una cita con él o con ella.	1	2	3	4	5	N/A
5. Sé los nombres de los medicamentos que tomo.	1	2	3	4	5	N/A
6. Sé y puedo decir porqué tomo los medicamentos.	1	2	3	4	5	N/A
7. Sé cómo volver a surtir mis medicamentos para que no me falten.	1	2	3	4	5	N/A
8. Sé cómo obtener ayuda si tengo problemas de alcohol o de drogas.	1	2	3	4	5	N/A
9. Sé lo que le puede pasarle a mi cuerpo si fumo, consumo alcohol y/o drogas controladas.	1	2	3	4	5	N/A
10. Puedo explicar los efectos secundarios de los medicamentos que tomo.	1	2	3	4	5	N/A
11. Demuestro tener el autocontrol adecuado.	1	2	3	4	5	N/A
12. Sé de algunas cosas que puedo hacer para manejar el estrés /la tensión.	1	2	3	4	5	N/A
13. Sé cómo puedo prevenir el embarazo y las enfermedades de transmisión sexual.	1	2	3	4	5	N/A
<b>ACCIONES/COMENTARIOS:</b> _____						
_____						

<b>CAPACIDAD PARA INTERACTUAR CON LOS DEMÁS</b>	<b>No, no sé</b>	<b>Sé un poco</b>			<b>Sí, sí sé</b>	<b>N/A</b>
1. En mi tiempo libre busco hacer cosas que no me metan en problemas.	1	2	3	4	5	N/A
2. En mi tiempo libre realizo actividades positivas que disfruto.	1	2	3	4	5	N/A
3. Formo parte de actividades en grupo (deportes, grupos juveniles, etc.)	1	2	3	4	5	N/A
4. Puedo explicar cómo me siento.	1	2	3	4	5	N/A
5. Puedo manejar situaciones que me enojan, sin necesidad de gritar, pegar o romper cosas.	1	2	3	4	5	N/A
6. Hablo de los problemas con mi familia y mis amigos.	1	2	3	4	5	N/A
7. Estoy dispuesto(a) a que mi familia o mis amigos me ayuden.	1	2	3	4	5	N/A
8. Tengo amigos de mi misma edad.	1	2	3	4	5	N/A
9. Sé comportarme educadamente con los demás.	1	2	3	4	5	N/A
10. Soy capaz de presentarme yo solo a personas que no conozco.	1	2	3	4	5	N/A
11. Sé cómo escuchar y sé hacer preguntas cuando quiero entender mejor algo.	1	2	3	4	5	N/A
12. Sé cómo ayudar a las otras personas que viven cerca de mí.	1	2	3	4	5	N/A
13. Puedo explicar mi formación cultural.	1	2	3	4	5	N/A
<b>ACCIONES/COMENTARIOS:</b> _____						
_____						

County of San Diego - CMHS

**Client:** \_\_\_\_\_

**InSyst #:** \_\_\_\_\_

**Program:** \_\_\_\_\_

<b>CAPACIDAD PARA SOBREVIVIR</b>	<b>No, no sé</b>	<b>Sé un poco</b>			<b>Sí, sí sé</b>	<b>N/A</b>
1. Sé a quién llamar en caso de una emergencia.	1	2	3	4	5	N/A
2. Mantengo mi cuerpo y mis dientes limpios.	1	2	3	4	5	N/A
3. Sé cómo lavar mi ropa.	1	2	3	4	5	N/A
4. Mantengo limpio mi cuarto.	1	2	3	4	5	N/A
5. Sé cómo comprar cosas en la tienda de comestibles.	1	2	3	4	5	N/A
6. Sé cómo preparar mis comidas.	1	2	3	4	5	N/A
7. Sé los alimentos que debo consumir para mantenerme sano(a).	1	2	3	4	5	N/A
8. Sé cómo sacar una licencia para conducir o una credencial de identificación de California.	1	2	3	4	5	N/A
9. Sé cómo transportarme en autobuses y en otro tipo de transporte público.	1	2	3	4	5	N/A
10. Puedo dar instrucciones sobre cómo llegar al lugar en donde vivo.	1	2	3	4	5	N/A
11. Puedo cuidarme a mi mismo(a) si estoy enfermo(a), y sé dónde conseguir ayuda.	1	2	3	4	5	N/A
12. Sé cómo componer algo en casa si está descompuesto.	1	2	3	4	5	N/A
13. Sé lo que puede ser peligroso en la casa y cómo eliminar el peligro.	1	2	3	4	5	N/A
14. Sé cómo buscar vivienda.	1	2	3	4	5	N/A
<b>ACCIONES/COMENTARIOS:</b>						

<b>FINANZAS</b>	<b>No, no sé</b>	<b>Sé un poco</b>			<b>Sí, sí sé</b>	<b>N/A</b>
1. Sé cómo manejar mi dinero para poder pagar siempre mis cuentas.	1	2	3	4	5	N/A
2. Sé cómo escribir un cheque, usar tarjeta de crédito o de débito, y sé cómo pagar en efectivo y recibir el cambio correcto.	1	2	3	4	5	N/A
3. Sé decidir que debo comprar primero cuando hay varias cosas que deseo y no suficiente dinero para todas.	1	2	3	4	5	N/A
4. Puedo explicar lo bueno y lo malo de comprar a crédito.	1	2	3	4	5	N/A
<b>ACCIONES/COMENTARIOS:</b>						

<b>EDUCACIÓN / PROFESIÓN</b>	<b>No, no sé</b>	<b>Sé un poco</b>			<b>Sí, sí sé</b>	<b>N/A</b>
1. Sé qué es lo que me ayuda a aprender cosas nuevas.	1	2	3	4	5	N/A
2. Sé lo que me gusta hacer.	1	2	3	4	5	N/A
3. Sé para lo que soy bueno.	1	2	3	4	5	N/A
4. Sé cuáles son mis metas de educación.	1	2	3	4	5	N/A
5. Sé cómo alcanzar mis metas de educación.	1	2	3	4	5	N/A
6. Sé el tipo de trabajo o de carrera que deseo tener.	1	2	3	4	5	N/A
7. Puedo explicar la educación y/o el entrenamiento que se necesita para las carreras que deseo seguir.	1	2	3	4	5	N/A
8. Puedo averiguar que tipo de actividades o de clases ofrece una organización.	1	2	3	4	5	N/A
9. Sé que llegar a tiempo al trabajo es muy importante, y yo puedo hacerlo.	1	2	3	4	5	N/A
10. Termino mi trabajo a tiempo.	1	2	3	4	5	N/A
11. Sigo las instrucciones de mi supervisor / profesor.	1	2	3	4	5	N/A
<b>ACCIONES/COMENTARIOS:</b>						

**STAFF TO SEE THE INSTRUCTIONS REGARDING ITEMS THAT MUST BE ADDRESSED**

County of San Diego - CMHS

**Client:** \_\_\_\_\_

**InSyst #:** \_\_\_\_\_

**Program:** \_\_\_\_\_

**YOUTH TRANSITION SELF-EVALUATION**

**Xin caùc baïn vui loøng ñoïc caùc khung döôùi ñây vaø khoanh troøn caâu naøo dieãn taù ñuùng nhaát con ngôôøi cuõa baïn**

SÖÜC KHOEÛ/SÖÜC KHOEÛ TAÂM THAÀN Chaéc chaén N/A	Khoàng , Khoàng chuët naøo				Vaâng, Phaàn naøo	
	1	2	3	4	5	N/A
1. Toái bieát giöø nhöõng dòch vuï taâm thaàn, hoaëc tieáp tuïc trôu laïi nhaän nhöõng dòch vuï naøy.	1	2	3	4	5	N/A
2. Toái bieát caùchlaáy baùn sao cuõa hoà sô toái neáu toái caàn.	1	2	3	4	5	N/A
3. Toái bieát toái bò ñau gì vaø tìm ñoïc söi giuùp ñoõ khi caàn.	1	2	3	4	5	N/A
4. Toái bieát tìm chuyeân vieân trò lieäu hoaëc baùc só vaø bieát saép xeáp buoái heïn.	1	2	3	4	5	N/A
5. Toái bieát teân nhöõng thöu thuoác toái uoáng.	1	2	3	4	5	N/A
6. Toái bieát vaø toái coù theå noùi taïi sao toái uoáng thuoác.	1	2	3	4	5	N/A
7. Toái bieát caùch coù theå thuoác uoáng ñeå khoûi bò heát thuoác.	1	2	3	4	5	N/A
8. Toái bieát tìm söi giuùp ñoõ neáu toái nghieän caàn sa hay nghieän röõu.	1	2	3	4	5	N/A
9. Toái bieát vieäc gì seõ xaùy ra cho theå xaùc toái khi toái duøng nhöõng loaïi ma tuøy baát hôïp phaùp, khi uoáng röõu hoaëc huët thuoác laù.	1	2	3	4	5	N/A
10. Toái coù theå giaûi thích phaûn öùng phuï do thuoác toái uoáng.	1	2	3	4	5	N/A
11. Toái coù thaùi ñoä töï chuù ñuùng luùc.	1	2	3	4	5	N/A
12. Toái bieát moät soá ñieàu toái coù theå laøm ñeå giaûi quyeaát söi caêng thaúng.	1	2	3	4	5	N/A
13. Toái bieát caùch ngaên ngôøa thuï thai vaø caùc beäähnh truyeàn nhieäm tinh duïc.	1	2	3	4	5	N/A
<b>BIEÁN PHAÛP/NHAÀN XEÛT:</b> _____						
_____						

Vaâng KYÕ NAËNG GIAO TEÁ chaén N/A	Khoàng, Khoàng chuët naøo				Phaàn naøo		Chaéc
	1	2	3	4	5		
1. Trong luùc roäi raõnh, toái tìm vieäc ñeå laøm ñeå khoûi sa vaøo nhöõng baát traéc.	1	2	3	4	5	N/A	
2. Toái coù thì giøø raõng rang ñeå tham gia nhöõng sinh hoaït maø toái thích.	1	2	3	4	5	N/A	
3. Toái coù tham gia sinh hoaït nhòum (theå thao, nhòum treù, vaân vaân...).	1	2	3	4	5	N/A	
4. Toái coù theå giaûi thích caûm nhaän cuõa toái.	1	2	3	4	5	N/A	
5. Toái coù theå giaûi quyeaát nhöõng vieäc khieán toái töüc giaän maø khoâng phaûi la heùt, ñaùng ñaám, hay ñaáp beå ñoä ñaïc.	1	2	3	4	5	N/A	
6. Toái thaùo luaän nhöõng vaán ñeå khoâng oån vòu baïn be/ø gia ñình toái.	1	2	3	4	5	N/A	
7. Toái saùn saøng ñeå gia ñình vaø baïn beø giuùp toái.	1	2	3	4	5	N/A	
8. Toái coù nhöõng ngôôøi baïn cuøng tuoái.	1	2	3	4	5	N/A	
9. Toái bieát cö xöù leä ñoä vòu moïi ngôôøi.	1	2	3	4	5	N/A	
10. Toái coù theå giöuùi thieäu chính toái vòu nhöõng ngôôøi	1	2	3	4	5	N/A	

County of San Diego - CMHS

**Client:** \_\_\_\_\_

**InSyst #:** \_\_\_\_\_

**Program:** \_\_\_\_\_

môi quen.						
11. Tôi biết làm một người chăm chú nghe, và nhớ các câu hỏi khi tôi muốn hiểu rõ hơn.	1	2	3	4	5	N/A
12. Tôi biết một vài cách để giúp những người khác sáng tạo hơn.	1	2	3	4	5	N/A
13. Tôi có thể giúp người khác nâng cao cuộc sống.	1	2	3	4	5	N/A
<b>BIỂU PHÁP/NHẬN XÉT:</b> _____						
_____						

KỸ NĂNG SỐNG MÃNG NGƯỜI Chắc chắn N/A	Không, Khoảng chút nào					Vâng, Hoàn toàn
		1	2	3	4	5
1. Tôi biết gọi ai khi cần giúp đỡ.	1	2	3	4	5	N/A
2. Tôi giỏi sắp xếp và quản lý thời gian.	1	2	3	4	5	N/A
3. Tôi biết cách tổ chức quán ăn.	1	2	3	4	5	N/A
4. Tôi giỏi phỏng vấn và sắp xếp.	1	2	3	4	5	N/A
5. Tôi biết mua sắm ở tiệm tạp hóa.	1	2	3	4	5	N/A
6. Tôi biết tìm kiếm các bữa ăn cho tôi.	1	2	3	4	5	N/A
7. Tôi biết phải ăn thức ăn nào để khỏe mạnh.	1	2	3	4	5	N/A
8. Tôi biết cách lái xe hay thuê chèo mình ra ngoài biển.	1	2	3	4	5	N/A
9. Tôi biết dùng xe buýt hay phương tiện giao thông công cộng khác.	1	2	3	4	5	N/A
10. Tôi có thể chờ đợi cho người ta nhận lời tôi gọi.	1	2	3	4	5	N/A
11. Tôi có thể tổ chức sự kiện khi tôi buồn hay mệt mỏi, và tôi biết nên làm gì để tìm sự giúp đỡ.	1	2	3	4	5	N/A
12. Tôi có thể sống chung với những thú cưng khác khi tôi ở nhà, giúp đỡ.	1	2	3	4	5	N/A
13. Tôi biết những việc nào an toàn ở nhà và biết cách sửa chữa.	1	2	3	4	5	N/A
14. Tôi có thể tìm một nơi để ở.	1	2	3	4	5	N/A
<b>BIỂU PHÁP/NHẬN XÉT:</b> _____						
_____						

TÀI CHÁNH Chắc chắn N/A	Không, Khoảng chút nào					Vâng, Hoàn toàn
		1	2	3	4	5
1. Tôi biết cách sử dụng tiền bạc nên tôi có thể trả tiền các hóa đơn.	1	2	3	4	5	N/A
2. Tôi biết cách viết 1 cái check, dùng tiền tín dụng hay tiền mặt, và tôi biết cách trả bằng tiền mặt và lấy tiền số tiền thừa lại.	1	2	3	4	5	N/A
3. Tôi biết quyết định mua cái gì trước trong số những thứ tôi cần và tôi biết tôi không nên mua tất cả.	1	2	3	4	5	N/A
4. Tôi có thể giúp người khác làm việc và bắt đầu khi mua đồ.	1	2	3	4	5	N/A
<b>BIỂU PHÁP/NHẬN XÉT:</b> _____						
_____						

County of San Diego - CMHS

Client: \_\_\_\_\_

InSyst #: \_\_\_\_\_

Program: \_\_\_\_\_

**YOUTH TRANSITION SELF-EVALUATION**

HOÏC VAÁN/ NGHEÀ NGHIEÄP naøo Chaéc chaén N/A	Khoâng Khoâng chuùt naøo					Vaâng, Phaàn
1. Toái bieát nhöõng gì giuùp toái hoïc hoüi ñieàu môüi.	1	2	3	4	5	N/A
2. Toái bieát toái thích laøm gì.	1	2	3	4	5	N/A
3. Toái bieát toái gioüi laøm vieác gì.	1	2	3	4	5	N/A
4. Toái bieát muïc ñích cuüa vieác hoïc vaán.	1	2	3	4	5	N/A
5. Toái bieát caùch ñaët ñöôïc muïc ñích hoïc vaán cuüa toái.	1	2	3	4	5	N/A
6. Toái bieát toái thích ngheà gì, vieác gì maø toái muoán laøm.	1	2	3	4	5	N/A
7. Toái còu theá giaüi thích hoïc vaán vaø huaán luyeän caàn phaüi còu ñeå cho toái chöiñ löa ngheà nghieáp.	1	2	3	4	5	N/A
8. Toái còu theá tìm ra caùc löüp vaø sinh hoaït maø caùc hoái ñoaøn cung caáp.	1	2	3	4	5	N/A
9. Toái bieát ñi laøm vieác ñuùng gioø moãi ngaøy raát quan troïng, vaø toái còu theá laøm ñöôïc.	1	2	3	4	5	N/A
10. Toái xong coâng vieác ñuùng gioø.	1	2	3	4	5	N/A
11. Toái laøm theo löøi chæ daãn cuüa giaùm ñoác / thaøy coá giaüo cuüa toái.	1	2	3	4	5	N/A
<b>BIEÁN PHAÛP/NHAÀN XEÛT:</b> _____						
_____						

**STAFF TO SEE INSTRUCTIONS REGARDING ITEMS THAT MUST BE ADDRESSED.**

County of San Diego - CMHS

**YOUTH TRANSITION SELF-EVALUATION**

HHS:MHS-624 (3/2005)

Page 2 of 2

**Client:** \_\_\_\_\_

**InSyst #:** \_\_\_\_\_

**Program:** \_\_\_\_\_

# PLANS

## Section 4

# CLIENT PLAN – ADULT MENTAL HEALTH

## COMPLETED BY:

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Licensed Psychiatric Technician
6. Registered Nurse
7. Nurse Practitioner
8. Trainee\*
9. Licensed Vocational Nurse\*
10. MHRS\*

## COMPLIANCE REQUIREMENTS:

1. Initial Client Plans shall be completed within 30 days of assignment open date to program (Day one is counter as the date of assignment).
2. Client Plans can be active for up to 12 months but should be updated prior to 12 months if clinically indicated.
3. All elements of the Client Plan must be addressed.
4. For the Client Plan to be active (cover services claimed), it must contain the signature of the client and/or the parent/guardian/care provider AND the service staff listed above AND Final Approved within CCBH;
  - a. If unable to obtain a client signature make sure to cross-reference the date of a progress note to explain why the client's signature was not obtained and their agreement in treatment, and/or
  - b. Continued efforts being made to obtain client's signature and involvement in Client Plan development. Signature shall be obtained at a later time when client is available to sign.
5. \* Trainee, Licensed Vocational Nurse, and MHRS can complete but must be co-signed by one of the above. Co-signatures must be completed within timelines.
6. Signature updates shall be obtained whenever an addition or modification is made to the Client Plan.

## DOCUMENTATION STANDARDS:

1. Providers are responsible to track the interval covered and assure that there is an active Client Plan in the client chart to cover all services claimed.
2. Unplanned services are not required to be a part of the plan, however if they become more frequent then the plan shall be updated to reflect the additional interventions offered to client.
3. Crisis Residential programs will complete the Client Plan START and Plan may only be active for up to 14 days.
4. When adding to a pre-existing Client Plan, do not remove and/or end other current providers goals, objectives, or interventions.
5. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible.

# CLIENT PLAN – CHILDREN’S MENTAL HEALTH

## COMPLETED BY:

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Licensed Psychiatric Technician
6. Registered Nurse
7. Trainee\*
8. MHRS\*

## COMPLIANCE REQUIREMENTS:

1. Initial Client Plans shall be completed within 30 days of assignment open date to program (Day one is counter as the date of assignment).
2. Client Plans can be active for up to 12 months maximum and must be driven by the appropriate authorization process.
  - a. Outpatient Programs: 13/18 sessions or COR approved exceptions
  - b. Day Treatment Intensive Programs: updated every 3 months but re-written annually.
  - c. Day Treatment Rehab Programs (full and half day): updated every 6 months but re-written annually.
3. All elements of the Client Plan must be addressed.
4. For the Client Plan to be active (cover services claimed), it must contain the signature of the client and/or the parent/guardian/care provider AND the service staff listed above AND Final Approved within CCBH.
5. Make sure to cross reference the date of a progress note to explain:
  - a. when a client’s signature is not obtained, why, and level of agreement with participation in treatment, and/or
  - b. when client is a Dependent of the Court and therefore no signature is obtained, and/or
  - c. when the parent/guardian/care provider is not available to sign the CP but provides verbal authorization, and/or
  - d. when explaining why a guardian’s signature is not obtained for any other reason.
6. \* Trainee, Licensed Vocational Nurse, and MHRS can complete but must be co-signed by one of the above. Co-signatures must be completed within timelines.
7. Signature updates shall be obtained whenever an addition or modification is made to the Client Plan.

## DOCUMENTATION STANDARDS:

1. Providers are responsible to track the interval covered and assure that there is an active Client Plan in the client chart to cover all services claimed.
2. Unplanned services, such as Crisis Intervention or inpatient stays, are not required to be a part of the plan.
3. Client Plans may be completed up to one month prior to the due date.
4. When adding to a pre-existing Client Plan, do not remove and/or end other current provider’s goals, objectives, or interventions.
5. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible.

**County of San Diego Mental Health Services  
CLIENT PLAN**

**Client Name**

**Case #**

**Program Name**

**Unit/SubUnit**

**Client Plan Begin Date**

**Client Plan End Date:**

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**PLANNING TIERS**

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**Strengths** (Identify client strength from the strengths table. These are what the client/support persons/staff identifies as general strengths for the client. Identify strength and individualize)

**Strength**  
**Strength**  
**Strength**  
**Strength**

**Area of Need # 1** (Identify need from the instructions. This is an area in which a level of impairment is identified by the client/support persons/staff. Identify the need and individualize)

**Need:**

**Goal for Need #1** (Identify the goal from the identified need. This is the broad goal that the client wants to achieve in treatment. Whenever possible the client's own words should be documented. Identify the goal and individualize)

**Goal:**

**Applied Strength for Goal/Need # 1** (Identify one of the strengths above. This is a specific strength that the client can utilize to achieve this goal. Identify the applied strength and individualize)

**Applied Strength**

**Objective #**            for Goal/Need #            (Identify the objective from the identified goal. There are no limits on the number of objectives for each goal – be sure to number each objective to match the designated goal. These are action steps that the client will focus on in order to achieve his/her goal. Identify the objective and individualize)

**Objective:**

# County of San Diego Mental Health Services

## CLIENT PLAN

**Interventions** for Objective # \_\_\_\_\_ (Identify each intervention. Service codes are considered interventions – each intervention may be individualized for how it will be used to assist the client achieve his/her goal)

**Intervention:**

**Area of Need #** \_\_\_\_\_ (Identify need from the instructions. This is an area in which a level of impairment is identified by the client/support persons/staff. Identify the need and individualize)

**Need:**

**Goal** for Need # \_\_\_\_\_ (Identify the goal from the identified need. This is the broad goal that the client wants to achieve in treatment. Whenever possible the client's own words should be documented. Identify the goal and individualize)

**Goal:**

**Applied Strength** for Goal/Need # \_\_\_\_\_ (Identify one of the strengths above. This is a specific strength that the client can utilize to achieve this goal. Identify the applied strength and individualize)

**Applied Strength:**

**Objective #** \_\_\_\_\_ for Goal/Need # \_\_\_\_\_ (Identify the objective from the identified goal. There are no limits on the number of objectives for each goal – be sure to number each objective to match the designated goal. These are action steps that the client will focus on in order to achieve his/her goal. Identify the objective and individualize)

**Objective:**

**County of San Diego Mental Health Services  
CLIENT PLAN**

**Interventions** for Objective # \_\_\_\_\_ (Identify each intervention. Service codes are considered interventions – each intervention may be individualized for how it will be used to assist the client achieve his/her goal)

**Intervention:**

(Add as many strengths/needs/applied strengths/goals/objectives/interventions as needed by repeating the above form fills.)

**Explained in client’s primary language of:**

**Explained in guardian’s primary language of:**

**Client offered a copy of the plan:**

Yes

No  (if no, document reason):

**SIGNATURES:**

**Client:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Refused to sign**      **Explanation:**

**Parent/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**County of San Diego Mental Health Services  
CLIENT PLAN**

**Conservator Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Other Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Signature of Staff Requiring Co-Signature:**

\_\_\_\_\_

**Date:** \_\_\_\_\_

\_\_\_\_\_  
**Printed Name**

**ID Number:** \_\_\_\_\_

**\*Signature of Staff Completing/Accepting Client Plan:**

\_\_\_\_\_

**Date:** \_\_\_\_\_

\_\_\_\_\_  
**Printed Name**

**ID Number:** \_\_\_\_\_

**County of San Diego Mental Health Services  
CLIENT PLAN**

**Client Name:** \_\_\_\_\_ **Case #:** \_\_\_\_\_

**Explained in client's primary language of:** \_\_\_\_\_

**Explained in guardian's primary language of:** \_\_\_\_\_

**Client offered a copy of the plan:**

**Yes** \_\_\_

**No** \_\_\_\_\_ (if no, document reason): \_\_\_\_\_

**SIGNATURES:**

**Client:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Refused to sign**      **Explanation:** \_\_\_\_\_

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Conservator Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Other Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**NOTES:**

The following items are required for an Anasazi Client Plan to be valid:

- Client Plan completed
- Client Plan electronically signed by Staff
- Client Plan co-signed electronically (if required)
- Client signature on this form
- Client Plan Final Approved in Anasazi

Client Plans will be valid on the date when the last of the above is completed.

County of San Diego Mental Health Plan  
**CONTINUING DAY TREATMENT REQUEST**

FAX/MAIL TO: **Optum Public Sector,**  
**P.O. Box 601340**  
**San Diego, CA 92160-1340**  
**Phone: (800) 798-2254, option #4**  
**Fax: (866) 220-4495**

RECEIVED:

**CLIENT INFORMATION**

Client Name:

Client ID:

**PROGRAM INFORMATION**

**Legal Entity & Program Name:** Phone:

Unit#: Subunit#: Assignment Open Date: Anticipated Discharge Date:

Current Session Frequency : days/week

**CONTINUED AUTHORIZATION REQUEST:**  Intensive Day Tx  Day Rehab Frequency : days/week

Begin Date for Request: End Date for Request: **See CFARS for DPR Cycle dated:**

**CURRENT CFARS Reviewed:**  YES  NO

**DAY TREATMENT MEDICAL NECESSITY CRITERIA – Include Significant Life Events Since Last Review**

**DIAGNOSIS:** List all diagnoses that are the focus of mental health treatment.

**Diagnosis 1:** **Diagnosis 2:** **Diagnosis 3:**

**SERVICE NECESSITY CRITERIA**

1. Client exhibits an impairment in functioning due to the above diagnosis as demonstrated by one or more of the following:
  - Substantial impairment in living arrangement, daily activities, social relationships, and/or age appropriate ADL skills as demonstrated by:
  - Risk factors such as recurring psychotic symptoms, suicidal or homicidal ideation without evidence of plan, or other violent ideation or behavior as demonstrated by:
  - Demonstrative history that without day treatment there is a substantial risk to child. Describe behavior/history of risk.
  - Probability that child will not progress developmentally as individually appropriate or will deteriorate developmentally as demonstrated by:
2.  Client (and family for children) has been in, or is currently in lower level of care and the client has not demonstrated progress or stabilization. Describe progress or lack of progress.
3.  Client requires structured day treatment in order to move successfully from higher to lower level of care or to prevent deterioration and admission to a higher level of care. Describe.
4.  Present living situation and functioning indicate need for structured day treatment. Describe living situation and functioning.
5.  Current treatment goals have not been met. There is progress toward treatment goals or a reasonable expectation that progress will be made during the next authorization cycle.

CLIENT INFORMATION	
Client Name:	Client ID:

TREATMENT GOALS: List goals directed at improving functioning. Progress Rating Scale: N – New Goal, 1 – Much worse, 2 – Somewhat worse, 3 – No change, 4 – Slight Improvement, 5 – Great improvement, R – Resolved			
Measurable Behavioral Goal:	As Demonstrated by:	Method(s) for Achieving Goal	Progress since last report

Client received psychiatric evaluation? <input type="checkbox"/> Yes <input type="checkbox"/> No NAME OF PSYCHIATRIST: _____
See electronic record for current list of medications.
PLEASE SUBMIT THE FOLLOWING WITH THIS CONTINUING DAY TREATMENT REQUEST.
<input type="checkbox"/> Specialty Mental Health Services DPR if the client receives ancillary services in addition to day treatment services.

Day Program Clinician: \_\_\_\_\_ Date: \_\_\_\_\_

Co-signature by Licensed Clinician: \_\_\_\_\_ Date: \_\_\_\_\_

<b>For OptumHealth Disposition Only: DOCUMENT AUTHORIZATIONS FOR DAY PROGRAM (DP) and ANCILLARY SERVICES (AS)</b> OptumHealth Clinician #: _____ Authorization Period: Begin Date: _____ End Date: _____ Approved # Days: _____ per week. Review Date: _____ Circle approved AS on next page(s) Logged <input type="checkbox"/> Reduce DP Request: <input type="checkbox"/> Deny DP Request: <input type="checkbox"/> Date NOA Sent: _____ Reduce AS Request: <input type="checkbox"/> Deny AS Request: <input type="checkbox"/> Date NOA Sent: _____ Date DP Auths Entered: _____ Date AS Auths Entered: _____ D/E Name: _____ Logged <input type="checkbox"/>
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County of San Diego Mental Health Plan  
**INITIAL DAY TREATMENT REQUEST**

FAX/MAIL TO: **Optum Public Sector,**  
P.O. Box 601340  
San Diego, CA 92160-1340  
Phone: (800) 798-2254, option #4  
Fax: (866) 220-4495

RECEIVED:

**CLIENT INFORMATION**

Client Name:

Client ID:

**PROGRAM INFORMATION**

Legal Entity & Program Name: Phone:

Unit#: Subunit#: Assignment Open Date: Anticipated Discharge Date:

**INITIAL AUTHORIZATION REQUEST:**  Intensive Day Treatment  Day Rehab Frequency: days/week

Begin Date for Request: End Date for Request: **See admission CFARS dated:**

**DAY TREATMENT MEDICAL NECESSITY CRITERIA**

**DIAGNOSIS:** List all diagnoses that are the focus of mental health treatment.

**Diagnosis 1:** **Diagnosis 2:** **Diagnosis 3:**

**SERVICE NECESSITY CRITERIA**

1. Client exhibits an impairment in functioning due to the above diagnosis as evidenced by one or more of the following:
  - Substantial impairment in living arrangement, daily activities, social relationships, and/or age appropriate ADL skills as demonstrated by:
  - Risk factors such as recurring psychotic symptoms, suicidal or homicidal ideation without evidence of plan, or other violent ideation or behavior as demonstrated by:
  - Demonstrative history that without day treatment there is a substantial risk to child. Describe behavior/history of risk.
  - Probability that child will not progress developmentally as individually appropriate, or will deteriorate developmentally as demonstrated by:
2.  Client (and family for children) has been in, or is currently in lower level of care and the client has not demonstrated progress or stabilization. Describe progress or lack of progress.
3.  Client requires structured day treatment in order to move successfully from higher to lower level of care or to prevent deterioration and admission to a higher level of care. Describe.
4.  Present living situation and functioning indicate need for structured day treatment. Describe living situation and functioning.
5.  Recent troubling life events, such as a change of placement, arrest and/or incarceration, or child abuse. Describe behaviors/functioning. A formal assessment must confirm medical necessity within 30 days after admission.

**CLIENT INFORMATION**

Client Name: \_\_\_\_\_ Client ID: \_\_\_\_\_

**PLEASE SUBMIT THE FOLLOWING WITH THIS INITIAL DAY TREATMENT REQUEST.**

Specialty Mental Health Services DPR if the client receives ancillary services in addition to day treatment services.

**Day Program Clinician:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Co-signature by Licensed Clinician:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**For OptumHealth Disposition Only: DOCUMENT AUTHORIZATIONS FOR DAY PROGRAM (DP) and ANCILLARY SERVICES (AS)**

OptumHealth Clinician #: \_\_\_\_\_ Authorization Period: Begin Date: \_\_\_\_\_ End Date: \_\_\_\_\_

Approved # Days: \_\_\_\_\_ per week. Review Date: \_\_\_\_\_ Circle approved AS on next page(s) Logged

Reduce DP Request:  Deny DP Request:  Date NOA Sent: \_\_\_\_\_

Reduce AS Request:  Deny AS Request:  Date NOA Sent: \_\_\_\_\_

**Date DP Auths Entered:** \_\_\_\_\_ **Date AS Auths Entered:** \_\_\_\_\_ **D/E Name:** \_\_\_\_\_ **Logged**

County of San Diego Mental Health Plan  
**SPECIALTY MENTAL HEALTH SERVICES (SMHS) DAY PROGRAM REQUEST**

FAX/MAIL TO: **Optum Public Sector,**  
**P.O. Box 601340**  
**San Diego, CA 92160-1340**  
**Phone: (800) 798-2254, option #4**  
**Fax: (866) 220-4495**

RECEIVED:

**Day Program shall submit form to Optum Public Sector.**  
**Forms submitted by SMHS Provider will be denied.**

**CLIENT INFORMATION**

Client Name:

Client ID:

**DAY PROGRAM INFORMATION**

Legal Entity & Day Program Name: Phone:

Unit#: Subunit#:

**SPECIALTY MENTAL HEALTH SERVICES (SMHS) PROGRAM INFORMATION**

Legal Entity & SMHS Program Name: Phone:

Unit#: Subunit#:

**AUTHORIZATION REQUEST for same day SMHS with Day Program.**

*Treatment must include **coordination of care** with other providers. Authorization is required only for ancillary services provided on the same day with Day Program Services.*

- *Ancillary Services provided in an Intensive Day Program require continued authorization within 3 months.*
- *Ancillary Services provided in a Day Rehab program require continued authorization within 6 months.*
- *No authorization is required for Medication Management, Case Management, TBS, and Crisis Intervention Services.*
- *Community services and/or self-help supports shall be coordinated with all providers treating client.*

**Enter below the total number of SMHS requested per week inclusive of all Individual, Collateral, and Group SMHS.**

**Request:** SMHS/week. Authorization Start Date: Authorization End Date:

SMHS Assignment Open Date:

**SMHS Medical Necessity**

- Requested service(s) is not available through the day program. Describe why service is not available.
- Continuity or transition issues make these services necessary for a limited time. Describe the need and time interval.
- These concurrent services are essential to coordination of care. Describe why services are essential.

**See current CFARS dated:**

**Requesting Clinician:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Co-signature by Licensed Clinician:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**INITIAL DAY PROGRAM REQUEST, CONTINUED DAY PROGRAM REQUEST,  
SPECIALTY MENTAL HEALTH SERVICES DPR**

**DAY PROGRAMS & ANCILLARY SERVICES**

**COMPLETED BY:**

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Registered Nurse\*
6. Trainee\*

**COMPLIANCE REQUIREMENTS:**

1. Initial authorization for Day Programs (and therefore ancillary programs) must be obtained by the seventh visit or twenty days after the Day Provider opens a client episode in EHR (whichever comes first).
2. Day Intensive must be re-authorized every three months.
  - a. Utilizing the Continued Day Program Request Form. Submitted to OPTUM at least 15 days before previous authorization expires. (For Day Intensive an authorization cycle may look like: Initial DPR 1/1/06 - 3/31/06, Continued DPR 4/1/06 - 6/30/06, etc.)
3. Day Rehabilitation must be re-authorized every six months.
  - a. Utilizing the Continued Day Program Request Form. Submitted to OPTUM at least 15 days before previous authorization expires. (For Day Rehab an authorization cycle may look like: Initial DPR 1/1/06 - 5/31/06, Continued DPR 6/1/06 - 11/30/06, etc.)
4. Outpatient providers (ancillary services) treating a client who is enrolled in a Day Program must obtain authorization through the Day Program Provider. Authorization is only required for Mental Health Services (not for Medication Support, TBS, Crisis Intervention, or CMBR which follow outpatient UR procedures). Ancillary providers must submit the Specialty Mental Health Services DPR Form to the Day Provider at least fifteen days prior to the end of the previous authorization so all forms can be submitted to OPTUM.
5. All fields must be complete and have required signatures.
6. CFARS must be completed and sent in to OPTUM with completed DPR form.

**DOCUMENTATION STANDARDS:**

1. \*RN's and Trainee may not diagnose a mental illness due to scope of practice. Therefore a co-signature of a licensed/registered/waivered staff must be provided.
2. In circumstances where retroactive authorization is needed, it may be granted through OPTUM.
3. Department of Mental Health (DMH) will not accept claims that are over one year old, and it takes up to 3 months for services to clear the system and be claimed. Thus, retroactive authorization should not be requested for services more than 9 months in the past. The Program Monitor must be notified via e-mail when submitting a retroactive authorization request.
4. DPRs should be filed in the medical record in the Plans section, or be accessible upon request. Optum will generate an Authorization Letter and send it to the Provider at the address provided to Optum within 14 business days. If a Provider does not receive the Letter within the 14 day timeline and is unable to access the information in EHR, please contact OPTUM directly. Authorization Letters should be attached to the corresponding DPR.

<b>Client:</b>	<b>Case #:</b>	<b>Program:</b>
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**Admission Date:**                      **Anticipated Discharge Date:**                      **Services:** MHS CM/BR Day Program Meds

**Outpatient Treatment Sessions Authorized:**

**Outpatient Treatment Sessions Authorized for AB2726 Clients (as documented in current IEP):**

**Day Treatment Interval Covered by Client Plan: From:**                      **To:**                      **Months Authorized:**

**OP Interval Covered (exception from COTR): From:**                      **To:**                      **Months Authorized:**

**Client offered copy of plan?** Yes No

**Explained in Client's Primary Language which is** English Spanish Vietnamese Arabic

**If not, explain:**

**Explained in Guardian's Primary Language which is** English Spanish Vietnamese Arabic

**If not, explain:**

**Client's Strengths:**

**Client's Challenges:**

**Client's Presenting Problem/Need # 1:**

**Behavior:**                      **Frequency:**

**Behavior:**                      **Frequency:**

**Behavior:**                      **Frequency:**

**Goal/Desired Outcome:**

**Objective 1:**

As Measured By:

Achieved On:                      Staff Name:

**Objective 2:**

As Measured By:

Achieved On:                      Staff Name:

**Objective 3:**

As Measured By:

Achieved On:                      Staff Name:

**Anticipated Duration to Achieve Objectives:**

**Interventions (specify modality/frequency/titration plan):**

County of San Diego - CMHS

**CLIENT PLAN Form Fill**  
HHSA:MHS-646 (Revised 03-01-10)

**Client:**

**Case #:**

**Program:**

**Client's Presenting Problem/Need # 2: :**

**Behavior:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

**Behavior:** \_\_\_\_\_ **Frequency:** \_\_\_\_\_

**Goals/Desired Outcomes:**

**Objective 1:**

As Measured By:

Achieved On: \_\_\_\_\_ Staff Name: \_\_\_\_\_

**Objective 2:**

As Measured By:

Achieved On: \_\_\_\_\_ Staff Name: \_\_\_\_\_

**Anticipated Duration to Achieve Objectives: :**

**Interventions (specify modality/frequency/titration plan):**

**COORDINATION OF CURRENT RESOURCES AND ANTICIPATED TRANSITION / DISCHARGE PLAN**

Other Mental Health Services:

Community Resources:

Alcohol/Drug Services:

Referral to Adult Mental Health: Yes No NA (client is under the age of 18) Other: \_\_\_\_\_

**SIGNATURES:**

**Client:** \_\_\_\_\_ Date: \_\_\_\_\_

See progress note dated \_\_\_\_\_ for explanation when client's signature is not obtained.

**Parent/Guardian:** \_\_\_\_\_ Date: \_\_\_\_\_

No signature due to client being a dependent of the court.

See progress note dated \_\_\_\_\_ for explanation when guardian's signature is not obtained.

**Service Staff:** \_\_\_\_\_ Credentials: \_\_\_\_\_ Date: \_\_\_\_\_

**Co-Signature** (if required) \_\_\_\_\_ Credentials: \_\_\_\_\_ Date: \_\_\_\_\_

**UPDATE (For Day Treatment Intensive Programs only):**

**Client:** \_\_\_\_\_ Date: \_\_\_\_\_

See progress note dated \_\_\_\_\_ for explanation when client's signature is not obtained.

**Parent/Guardian:** \_\_\_\_\_ Date: \_\_\_\_\_

No signature due to client being a dependent of the court.

See progress note dated \_\_\_\_\_ for explanation when guardian's signature is not obtained.

**Service Staff:** \_\_\_\_\_ Credentials: \_\_\_\_\_ Date: \_\_\_\_\_

**Co-Signature** (if required) \_\_\_\_\_ Credentials: \_\_\_\_\_ Date: \_\_\_\_\_

**COMPLETED BY:**

1. Client;
2. Guardian (if applicable); and
3. Service Provider

**COMPLINACE REQUIREMENTS:**

1. “My Safety Plan” should be completed when there is risk or concern that crisis intervention may be needed.
2. It should be updated throughout treatment as needed.
3. All elements must be completed.

**DOCUMENTATION STANDARDS:**

1. Formulation of the plan is a collaborative effort with the client and family.
2. The Plan can either be handwritten or typed.
3. A hard copy of the Plan should be kept in the hybrid chart and documentation of completion should be in a note within the Electronic Health Record (EHR).
4. “My Safety Plan” is intended to be a helpful resource for clients and families during times of crises or risk of crises.
5. It shall be completed in lieu of a “Safety Contract” and “No Harm Contract”.
6. In reference to item #2 on “My Safety Plan”, include both the client’s words/preferences, and clinically appropriate interventions, as well as helpful things client identified in their WRAP Plan if he/she completed one.
7. In reference to item #3 on “My Safety Plan”, list as many relevant supports as available. Do not limit to just professional supports.
8. In reference to item #5 on “My Safety Plan”, list professional supports such as the client’s counselor, Care Coordinator, and the program’s on-call counselor after business hours.

## خطة سلامتي

نحن نفهم أن هناك أوقات يشعر فيها المرء وكأن الحياة تسحقه. في تلك الأوقات، يشعر المرء أحياناً باليأس أو يعتقد أن الأمور لن تتحسن أبداً. إن سلامتك هي أولويتنا القصوى، وهدفنا هو مساعدتك على البقاء سالمًا في الأوقات الصعبة. تساعد العناصر التالية على تحديد متى قد تحتاج إلى دعم أكثر وخطوات يمكنك أنت ومن يشاركون حياتك أن تتخذها للمساعدة.

1. علامات التحذير الأولى التي تخبرني أنني قد أحتاج إلى المساعدة هي:

2. الأمور التي يمكنني القيام بها لمساعدة نفس خلال هذه الأوقات هي:

3. الأشخاص الذين يمكنهم دعمي (الأسرة، الأصدقاء، المجتمع، وما شابه) هم (اذكر الأسماء وصلة القرابة وأرقام الهواتف):

الاسم	الصلة	رقم الهاتف

4. الأمور التي يمكن لمن يدعمونني القيام بها هي:

5. أعضاء فريق علاجي الذين يمكنني الاتصال بهم:

الاسم	الصلة	رقم الهاتف

6. إذا لم تكن الموارد أعلاه متاحة، فإن موارد المجتمع الأخرى المتاحة لي هي (حدد كل ما ينطبق):

خط الوصول والأزمات (Access & Crisis Line) على الرقم 888-724-7240. متوفر 24 ساعة/7 أيام في الأسبوع. تتوفر لغات أخرى بخلاف الإنجليزية. تتوفر الدردشة الحية أيضًا من الإثنين إلى الجمعة من الساعة 4:00 مساءً وحتى 10:00 مساءً عبر الكمبيوتر أو الهاتف الذكي على [www.optumsandiego.com](http://www.optumsandiego.com) أو [www.up2sd.org](http://www.up2sd.org).

911. إذا شعرت أنك معرض لخطر طارئ فوري، لا تتردد في الاتصال. استفسر عن توفر PERT.

وحدة الطب النفسي الطارئ في مقاطعة سان دييغو (San Diego County Emergency Psychiatric Unit) على الرقم 619-692-8200 وتقع في العنوان 3853 Rosecrans Street، San Diego، CA 92110. متوفرة للبالغين للمساعدة النفسية الطارئة.

وحدة التشخيص الطارئ لمقاطعة سان دييغو (San Diego County Emergency Screening Unit) على الرقم 619-421-6900 وتقع في العنوان 730 Medical Center Court، Chula Vista، CA، 91911. متوفرة للأطفال والمراهقين للمساعدة النفسية الطارئة.

خط ائتلاف كاليفورنيا لأزمات الشباب (California Coalition for Youth Crisis Line) على الرقم 1-800-843-5200. متوفر 24 ساعة/7 أيام في الأسبوع. تتوفر لغات أخرى بخلاف الإنجليزية. مجهول الهوية وسري للشباب والشباب في العمر الانتقالي الذين يعانون من مشاكل سلوكية. يوفر موارد مجتمعية محلية للشباب والأسرة. تتوفر الدردشة النصية والحية من الساعة 4:30 مساءً وحتى 8:30 مساءً يوميًا عبر الموقع الإلكتروني [www.calyouth.org](http://www.calyouth.org) أو عبر الهاتف على الرقم 1-800-843-5200.

خط WARM بين المستهلكين (Consumer-to-Consumer WARM Line) على الرقم 1-800-930-9276 (WARM). يوميًا: 3:30 مساءً - 11:00 مساءً.

الخط الساخن الوطني لمنع الانتحار على الرقم 1-800-273-8255 (TALK). خط ساخن متوفر 24 ساعة لأي شخص في أزمة.

خطة استجابة طوارئ الصحة السلوكية لمقاطعة سان دييغو (SD County Behavioral Health Emergency Response Plan). هذه الوثيقة لي لأعنيها وأحتفظ بها معي. وهي تحتوي على معلومات مهمة تنبغي مشاركتها مع فرق الاستجابة للطوارئ في حال الاتصال بهم لمساعدتي. (إذا تم تحديد هذا الخيار، فهو إشارة إلى أنني أتممت خطة استجابة الطوارئ).

غير ذلك (اذكر الاسم ورقم الهاتف)

المستشفى أو بيت الأزمات المختار: (اذكر الاسم ورقم الهاتف):

أنا أفهم أن الطاقم يحاول مساعدتي وسأقوم بأفضل ما في وسعي للبقاء سالمًا.

توقيع العميل: تاريخ التوقيع:

توقيع ولي الأمر/الوصي: تاريخ التوقيع:

## My Safety Plan

We understand that there may be times when life feels overwhelming. During these times, sometimes people feel hopeless or think things will never get better. Your safety is our highest priority and our goal is to help you stay safe when difficult times arise. The items below help to identify when you may need more support and action steps you and the people in your life can take to help.

1. Early warning signs that tell me I may need help are:
2. Things I can do to help myself during these times are:
3. People who can support me (family, friends, community, etc.) are (list name, relationship and phone numbers):

Name	Relationship	Phone Number

4. Things my support persons can do to help are:
5. Members of my treatment team I can call:

Name	Relationship	Phone Number

6. If the above resources are not available, other community resources available to me are (check all that apply):

- The Access & Crisis Line at 888-724-7240.** Available 24 hours/7 days a week. Languages other than English are available. Live Chat is also available Monday-Friday from 4:00pm-10:00pm via computer or smartphone at [www.optumsandiego.com](http://www.optumsandiego.com) or [www.up2sd.org](http://www.up2sd.org).
- 911.** If you feel you are in immediate danger of emergency, do not hesitate to call. Ask if PERT is available.
- San Diego County Emergency Psychiatric Unit at 619-692-8200, located at 3853 Rosecrans Street, San Diego, CA 92110.** Available to adults for emergency psychiatric assistance.
- San Diego County Emergency Screening Unit at 619-421-6900, located at 730 Medical Center Court, Chula Vista, CA, 91911.** Available to children and adolescents for emergency psychiatric assistance.
- California Coalition for Youth Crisis Line at 1-800-843-5200.** Available 24 hours/7 days a week. Languages other than English are available. Anonymous and confidential for those youth and TAY struggling with behavioral issues. Provides local community resources for youth and family. Text and live chat are available from 4:30pm-8:30pm daily via the website [www.cal youth.org](http://www.cal youth.org) or phone 1-800-843-5200.
- Consumer-to-Consumer WARM Line at 1-800-930-9276 (WARM).** Daily: 3:30 p.m.—11:00 p.m.
- National Suicide Prevention Hotline at 1-800-273-8255 (TALK).** A 24-hour hotline available to anyone in crisis.
- SD County Behavioral Health Emergency Response Plan (ERP).** This is a document for me to fill out and keep with me. It has important information to share with emergency response teams if they are called to assist me. (If checked, this indicates I've completed an ERP).
- Other** (list name and phone #)

Hospital or Crisis House of choice: (list name and phone #):

I understand that the staff is trying to help me and I will do my best to stay safe.

Client Signature:

Date Signed:

Parent/Guardian Signature:

Date Signed:

## Mi plan de seguridad

Entendemos que puede haber ocasiones en donde la vida parece ser abrumadora. Durante estas épocas, las personas a veces se sienten sin esperanza o piensan que las cosas nunca mejorarán. Su seguridad es nuestra mayor prioridad y nuestra meta es ayudarlo a permanecer seguro cuando se presentan estos momentos difíciles. Los puntos que se incluyen a continuación le ayudan a identificar cuándo puede ser que necesite más apoyo y los pasos de acción que puede tomar usted y las personas en su vida para ayudar.

1. Las señales de advertencia temprana que me indican que podría necesitar ayuda son:
2. Las cosas que puedo hacer para ayudarme a mí mismo durante estos momentos son:
3. Las personas que me pueden apoyar (familia, amigos, comunidad, etc.) son (escribir el nombre, filiación y números de teléfono):

Nombre	Filiación	Número de teléfono

4. Las cosas que pueden hacer las personas que me apoyan para ayudarme son:
5. Los miembros de mi equipo de tratamiento a quien puedo llamar:

Nombre	Filiación	Número de teléfono

6. Si los recursos anteriores no están disponibles, otros recursos comunitarios disponibles para mí son (marcar todos los que se aplican):

**La línea de Acceso y Crisis marcando al (888) -724-7240.** Disponible las 24 horas del día, los 7 días de la semana. Se cuenta con idiomas disponibles diferentes al inglés. También se cuenta con Chats en Vivo de lunes a viernes de 4:00 p.m.-10:00 p.m. a través de una computadora o Smartphone en [www.optumsandiego.com](http://www.optumsandiego.com) o [www.up2sd.org](http://www.up2sd.org).

**911.** No dude en llamar si siente que se encuentra en un peligro inmediato de emergencia. Pregunte si se cuenta con PERT.

**Unidad Psiquiátrica de Emergencia del Condado de San Diego llamando al 619-692-8200, ubicada en 3853 Rosecrans Street, San Diego, CA 92110.** Disponible para adultos para recibir asistencia psiquiátrica de emergencia.

**Unidad de Selección de Emergencia del Condado de San Diego llamando al 619-421-6900, ubicada en 730 Medical Center Court, Chula Vista, CA 91911.** Disponible para niños y adolescentes para recibir asistencia psiquiátrica de emergencia.

**Línea de la Coalición de California para Jóvenes en Crisis llamando al 1-800-843-5200.** Disponible las 24 horas del día, los 7 días de la semana. Se cuenta con idiomas disponibles diferentes al inglés. Servicio anónimo y confidencial para aquellos jóvenes y TAY que están luchando con cuestiones de comportamiento. Proporciona recursos comunitario locales para jóvenes y familias. Textos y chats en vivo están disponibles de 4:30 p.m.-8:30 p.m. diariamente a través del sitio [www.calyouth.org](http://www.calyouth.org) o por teléfono llamando al 1-800-843-5200.

**Línea WARM de Consumidor a Consumidor llamando al 1-800-930-9276 (WARM).** A diario: 3:30 p.m.—11:00 p.m.

**Línea Nacional de Asistencia de Prevención del Suicidio llamando al 1-800-273-8255 (TALK).** Línea de asistencia disponible las 24 horas para cualquier persona en crisis.

**Plan de Respuesta ante Emergencias (ERP) de Salud Conductual del Condado de SD.** Este es un documento que tengo que llenar y conservar. Cuenta con información importante que compartir con los equipos de respuesta ante emergencias si son llamados para asistirme. (Si se marcó, esto indica que llené un ERP).

**Otro** (escribir nombre y número de teléfono)

Hospital o Casa de Crisis preferida: (escribir nombre y número de teléfono):

Yo entiendo que el personal está tratando de ayudarme y yo voy a poner mi mejor esfuerzo para mantenerme seguro.

Firma del cliente:

Fecha de la

firma:

Firma del padre/tutor:

Fecha de la

firma:

### **My Safety Plan (Ang Aking Planong Pangkaligtasan)**

Nauunawaan namin na may mga panahon na tila ang buhay ay nakakapanaig. Sa mga ganitong panahon, minsan ay tila nawawalan ng pag-asa ang mga tao o palagay nila na hindi na maaayos ang mga bagay-bagay. Ang inyong kaligtasan ang aming nangungunang priyoridad at ang aming layunin ay mapanatili kayong ligtas kapag may dumating na kahirapan. Ang mga bagay na nakalista sa ibaba ay makakatulong para kilalanin kung kailan maaaring kailangan ninyo ng karagdagang suporta at kilos na magagawa ninyo at ng mga taong pumapaligid sa inyo para matulungan kayo.

1. Ang maagang hudyat na nagpapahiwatig sa akin na maaaring kailangan ko ng tulong ay:
2. Mga bagay-bagay na magagawa ko upang matulungan ang aking sarili sa mga ganitong uri ng panahon ay:
3. Ang mga taong makakapagbigay-suporta sa akin (pamilya, mga kaibigan, komunidad, atbp.) ay (ilista ang mga pangalan, ugnayan at numero ng telepono):

<b>Pangalan</b>	<b>Ugnayan</b>	<b>Numero ng Telepono</b>

4. Ang mga bagay-bagay na magagawa ng mga taong sumusuporta sa akin upang matulungan ako ay:
5. Mga miyembro ng aking pangkat sa paggagamot na matatawagan ko:

<b>Pangalan</b>	<b>Ugnayan</b>	<b>Numero ng Telepono</b>

6. Kung ang mga nakasaad sa itaas na mapagkukuhanan ng tulong at impormasyon ay hindi handang magamit, ang iba pang mga dulugan sa komunidad na magagamit ko ay (lagyan ng tsek ang lahat ng naaangkop):

**Ang Access & Crisis Line sa 888-724-7240.** Matatawagan 24 oras sa isang araw, 7 araw sa isang linggo. May iba pang available na mga wika maliban sa Ingles. Ang Live Chat ay available rin Lunes-Biyernes mula 4:00pm-10:00pm sa pamamagitan ng computer o smartphone sa [www.optumsandiego.com](http://www.optumsandiego.com) o [www.up2sd.org](http://www.up2sd.org).

**911.** Kung pakiramdam ninyo na kayo ay nasa ilalim ng kagyat na panganib na emerhensya, huwag mag-atubiling tumawag. Tanungin kung available ang PERT.

**San Diego County Emergency Psychiatric Unit sa 619-692-8200, na matatagpuan sa 3853 Rosecrans Street, San Diego, CA 92110.** Available sa mga adult para sa emergency na psychiatric na tulong.

**San Diego County Emergency Screening Unit sa 619-421-6900, na matatagpuan sa 730 Medical Center Court, Chula Vista, CA, 91911.** Available sa mga bata at teenager para sa emergency na psychiatric na tulong.

**California Coalition for Youth Crisis Line sa 1-800-843-5200.** Matatawagan 24 oras sa isang araw/7 araw sa isang linggo. May iba pang available na mga wika maliban sa Ingles. Maaaring hind magpakilala at ituring na kompidensyal para doon sa mga kabataan at TAY na may mga problema sa mga isyu na may kinalaman sa pag-uugali. Nagkakaloob ng mga mapagkukuhanan ng tulong at impormasyon sa mga lokal na komunidad para sa mga kabataan at mga pamilya. Ang text at live chat ay handang magamit mula 4:30pm-8:30pm araw-araw sa pamamagitan ng website [www.calyouth.org](http://www.calyouth.org) o sa telepono 1-800-843-5200.

**Consumer-to-Consumer WARM Line sa 1-800-930-9276 (WARM).** Araw-araw: 3:30 p.m.—11:00 p.m.

**National Suicide Prevention Hotline sa 1-800-273-8255 (TALK).** Isang 24 oras na hotline ay handang magamit ng sinuman na may krisis.

**SD County Behavioral Health Emergency Response Plan (ERP).** Ito ay isang dokumento na dapat kong kompilahin at dalhin parati. Ito ay may mahahalagang impormasyon na maibabahagi sa mga emergency reponse team kung tawagan sila para tulungan ako. (Kung may tsek, nangangahulugan na nakumpleto ko na ang isang ERP).

**Iba pa** (ilista ang pangalan at num. ng telepono)

Napiling ospital o Crisis House: (ilista ang pangalan at num. ng telepono) :

Nauunawaan ko na ang staff ay sinusubukan akong tawagan at gagawin ko ang lubos ng aking makakayanan para manatiling ligtas.

Lagda ng Kliyente:

Petsa ng

Paglilagda:

Lagda ng  
Magulang/Tagapag-alaga:

Petsa ng  
Paglilagda:

## Kế Hoạch An Toàn Của Tôi

Chúng tôi hiểu rằng có thể có những lúc đời sống cảm thấy quá nhiều áp đảo. Trong những lúc như vậy, đôi khi người ta cảm thấy tuyệt vọng hoặc cho rằng hoàn cảnh sẽ không bao giờ tốt đẹp hơn. Sự an toàn của quý vị là ưu tiên hàng đầu của chúng tôi và mục tiêu của chúng tôi là giúp quý vị được an toàn khi những thời điểm khó khăn phát sinh. Những đề mục dưới đây giúp xác định khi nào quý vị có thể cần được yểm trợ thêm và những bước hành động mà quý vị và những người trong đời sống quý vị có thể thực hiện để giúp đỡ.

1. Những dấu hiệu cảnh báo sớm cho tôi biết là tôi có thể cần được giúp đỡ là:
2. Những điều tôi có thể làm để giúp bản thân trong những lúc này là:
3. Những người có thể yểm trợ tôi (gia đình, bạn bè, cộng đồng, v.v.) là (liệt kê tên họ, mối liên hệ và số điện thoại):

Tên Họ	Mối Liên Hệ	Số Điện Thoại

4. Những điều mà người yểm trợ tôi có thể làm để giúp đỡ là:
5. Những thành viên trong nhóm chữa trị của tôi mà tôi có thể liên lạc:

Tên Họ	Mối Liên Hệ	Số Điện Thoại

6. Nếu những nguồn giúp đỡ trên không có sẵn, những nguồn giúp đỡ từ cộng đồng có sẵn cho tôi là (đánh dấu tất cả những mục nào áp dụng):

**Access & Crisis Line (Đường Dây Tiếp Xúc & Khủng Hoảng) ở số 888-724-7240.** Sẵn sàng 24 giờ/7 ngày trong một tuần. Cung cấp các ngôn ngữ ngoài tiếng Anh. Live Chat (Trò Chuyện Trên Mạng) cũng được cung cấp Thứ Hai-Thứ Sáu từ 4 giờ chiều đến 10 giờ tối qua máy điện toán hoặc điện thoại thông minh tại [www.optumsandiego.com](http://www.optumsandiego.com) hay [www.up2sd.org](http://www.up2sd.org).

**911.** Nếu quý vị cảm thấy mình đang ở trong tình trạng nguy hiểm và cần cấp cứu ngay, đừng do dự khi gọi. Hãy hỏi xem có PERT hay không.

**Ban Cấp Cứu Tâm Thần Quận San Diego ở số 619-692-8200, tọa lạc tại 3853 Rosecrans Street, San Diego, CA 92110.** Sẵn sàng trợ giúp cấp cứu tâm thần cho người lớn.

**Ban Thanh Lọc Cấp Cứu Quận San Diego ở số 619-421-6900, tọa lạc tại 730 Medical Center Court, Chula Vista, CA, 91911.** Sẵn sàng trợ giúp cấp cứu tâm thần cho trẻ em và thanh thiếu niên.

**Đường Dây Khủng Hoảng của Liên Minh Thanh Thiếu Niên California ở số 1-800-843-5200.** Sẵn sàng 24 giờ/7 ngày trong một tuần. Cung cấp các ngôn ngữ ngoài tiếng Anh. Nặc danh và giữ kín cho những thanh thiếu niên và TAY đang gặp những vấn đề khó khăn về hành vi. Cung cấp các nguồn giúp đỡ từ cộng đồng địa phương cho thanh thiếu niên và gia đình. Nhắn tin và trò chuyện trên mạng được cung cấp từ 4:30 chiều đến 8:30 tối mỗi ngày qua website [www.calyouth.org](http://www.calyouth.org) hoặc điện thoại số 1-800-843-5200.

**Đường Dây WARM Từ Người Tiêu Thụ đến Người Tiêu Thụ ở số 1-800-930-9276 (WARM).** Hàng ngày: 3:30 chiều—11:00 giờ tối.

**Đường Dây Trực Tiếp Ngăn Chặn Tự Tử Toàn Quốc at 1-800-273-8255 (TALK).** Một đường dây trực tiếp 24 giờ sẵn sàng cho bất cứ ai bị khủng hoảng.

**Kế Hoạch Ứng Phó Cấp Cứu (ERP) về Sức Khỏe Hành Vi Quận San Diego.** Đây là một văn kiện mà tôi phải điền vào và mang theo trong người. Văn kiện này có những chi tiết quan trọng để chia sẻ với các toán ứng phó cấp cứu nếu họ được gọi đến để giúp đỡ tôi. (Nếu được đánh dấu, thì điều này cho thấy rằng tôi đã hoàn tất một ERP).

**Người giúp đỡ khác** (liệt kê tên họ và số điện thoại #)

Bệnh Viện hoặc Nhà Khủng Hoảng được chọn: (liệt kê tên họ và số điện thoại):

Tôi hiểu rằng ban nhân viên đang tìm cách giúp tôi và tôi sẽ cố hết sức để giữ an toàn.

Chữ Ký của Thân Chủ:

Ngày Ký Tên:

Chữ Ký của Phụ  
Huynh/Người Giám Hộ:

Ngày Ký Tên:

## STRENGTHS TABLE

Ability to Form and Maintain Relationships  
Ability to Manage Activities of Daily Living  
Ability to Navigate Public Transportation  
Academic History  
Accepts Feedback from Others  
Accepts Responsibility  
Actively Seeking Information about Change  
Adaptable  
Adaptive Distancing/Resistance  
Adequate Decision-making Skills  
Adventurous  
Affectionate  
Alert  
Ambitious  
Artistic  
Athletic  
Attentive  
Bold  
Brave  
Calm  
Capable  
Charming  
Cheerful  
Clean-cut Appearance  
Communicates Well  
Communication  
Compassion/Altruism  
Competent  
Conscientious  
Considerate  
Creative

Curious  
Daily Living Skills  
Dependable  
Drug-free  
Easy-going Appearance  
Effective  
Efficient  
Empathy/Caring  
Energetic  
Enterprising  
Exercises Regularly  
Faith/Spirituality  
Flexibility  
Forgiving  
Goal-Directed/Motivated  
Hard-working  
Has Transportation  
Hobbies/Special Interests  
Honest  
Humble  
Independent  
Insight/Critical Thinking  
Intelligent  
Internal Locus of Control  
Kind  
Likeable  
Living Environment  
Long-term Sobriety in Past  
Loyal  
Maintaining Personal Changes  
Manages Finances Adequately

## STRENGTHS TABLE

Mature	Responsible
Meticulous	Responsiveness
Open to Change	Self-Awareness
Open-minded	Self-Efficacy/Mastery
Optimism/Hope	Self-sacrificing
Organized	Sense of Empowerment
Other	Sense of Humor
Outgoing	Sense of Meaning
Patient	Sensitive
Peaceful	Serious
Physically Active	Stable Environment
Physically Attractive	Stable Family Life
Physically Healthy	Steady Demeanor
Physically Strong	Strong Cultural Identity
Physically Tough	Support System
Physically Versatile	Sympathetic
Planning	Tactful
Positive Identity	Taking Action for Personal Change
Positive Relationship with Parents	Tolerant
Positive Relationship with Siblings	Trusting
Practices Good Nutrition	Trustworthy
Prayerful	Utilizes Agreed-Upon Treatment Recommendations
Previous Positive Experience in Treatment	Verbal
Professional Demeanor	Vocational Skills
Quick Learner	Wants to Work
Reflective	Warm Personality
Relaxed	Wholesome
Religious	Wise
Reserved	Work History
Resourcefulness	

**County of San Diego Mental Health Services  
TBS CLIENT PLAN**

**Client Name:**                      **Case #:**

**Program Name:**                      **Unit/SubUnit:**

**Client Plan Begin Date:**                      **Client Plan End Date:**

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**PLANNING TIERS**

(Print as many pages as needed)

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**Strengths** (Identify client strength from the strengths table. These are what the client/support persons/staff identifies as general strengths for the client. Identify strength and individualize)

**Strength:**

**Strength:**

**Strength:**

**Strength:**

**Area of Need #**                      (Identify need from the instructions. This is an area in which a level of impairment is identified by the client/support persons/staff. Identify the need and individualize)

**Need:**

**SPECIFIC TARGET BX:**

**FREQUENCY/DURATION/INTENSITY of BX:**

**ANTECEDENTS:**

**Goal for Need #**                      (Identify the goal from the identified need. This is the broad goal that the client wants to achieve in treatment. Whenever possible the client's own words should be documented. Identify the goal and individualize)

**Goal:**

**Applied Strength for Goal/Need #**                      (Identify one of the strengths above. This is a specific strength that the client can utilize to achieve this goal. Identify the applied strength and individualize)

**Applied Strength:**

**Objective #**                      for Goal/Need #                      (Identify the objective from the identified goal. There are no limits on the number of objectives for each goal – be sure to number each objective to match the designated goal.)

(Page #        of        )

# County of San Diego Mental Health Services

## TBS CLIENT PLAN

These are action steps that the client will focus on in order to achieve his/her goal. Identify the objective and individualize)

**Objective:**

**MONTH 1 OBJECTIVE:**

**MONTH 2 OBJECTIVE:**

**MONTH 3 OBJECTIVE:**

**MONTH 4 OBJECTIVE:**

**CLT WILL:**

**CAREGIVER WILL:**

**COACH WILL:**

**SPECIALTY MENTAL HEALTH PROVIDER (SMHP) WILL:**

**SUPPORT STAFF WILL:**

**Interventions for Objective #** (Identify each intervention. Service codes are considered interventions – each intervention may be individualized for how it will be used to assist the client achieve his/her goal)

**Intervention:**

**Intervention:**

**Intervention:**

**Intervention:**

(Additional Areas of Need, Goals, Objectives, Interventions on following pages  
Print as many as needed)

## County of San Diego Mental Health Services TBS CLIENT PLAN

\*Client was offered a copy of plan?  Yes  No

\*Explained in Client's Primary Language, which is:  
If not, explain:

\*Explained in Caretaker's Primary Language, which is:  
If not, explain:

\*Transition Plan:

**Outcome Goal (Identify)**

- Avoid psychiatric hospitalization
- Prevent higher level of care
- Move to lower level of care

**Achieved**

- Yes  No  N/A
- Yes  No  N/A
- Yes  No  N/A

**Explanation (If No or N/A)**

Coach Start Date:

Anticipated Discharge Date:

**TBS Hours:**

From	To	Days/Times	Hours

**Signature of TBS Staff Requiring Co-Signature:**

\_\_\_\_\_

**Date:** \_\_\_\_\_

\_\_\_\_\_  
**Printed Name**

**ID Number:** \_\_\_\_\_

**\*Signature of TBS Staff Completing/Accepting Client Plan:**

\_\_\_\_\_

**Date:** \_\_\_\_\_

\_\_\_\_\_

**ID Number:** \_\_\_\_\_

\* Denotes Required Fields in Anasazi

**County of San Diego Mental Health Services  
TBS CLIENT PLAN SIGNATURE PAGE**

Client Name: \_\_\_\_\_ Case #: \_\_\_\_\_

Explained in client's primary language of: \_\_\_\_\_

Explained in guardian's primary language of: \_\_\_\_\_

Client offered a copy of the plan:

Yes \_\_\_\_\_

No \_\_\_\_\_ (if no, document reason): \_\_\_\_\_

**SIGNATURES:**

Client: \_\_\_\_\_ Date: \_\_\_\_\_

Refused to sign Explanation: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of TBS Staff Requiring Co-Signature:

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ ID Number: \_\_\_\_\_

Printed Name

\*Signature of TBS Staff Completing/Accepting Client Plan:

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ ID Number: \_\_\_\_\_

Printed Name

TBS Coach Signature: \_\_\_\_\_ Date: \_\_\_\_\_

ID Number: \_\_\_\_\_

SMHP Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title

Other Signature: \_\_\_\_\_ Date: \_\_\_\_\_

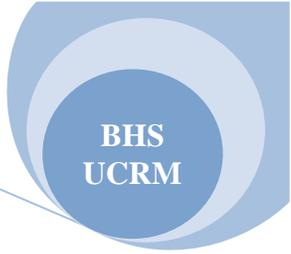
Title

Other Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title

Other Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title



**COMPLETED BY:**

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Licensed Psychiatric Technician
6. Registered Nurse
7. Trainee\*
8. MHRS\*

**COMPLIANCE REQUIREMENTS:**

1. A Therapeutic Behavioral Services (TBS) Client Plan must be completed prior to the TBS Coach(s) start date.
2. At least a minimal Client Plan shall be completed by the end of the initial authorization period (thirty days from the contractor’s opening the client’s assignment).
3. Additionally, a Client Plan shall be reviewed and updated at each monthly review meeting and whenever there is a significant change in the client’s planned care.
4. When services continue to be needed, the Client Plan shall also be rewritten at the third month review meeting.
5. All elements must be completed.
6. For the CP to be active (cover services claimed), it must contain the following signatures:
  - a. Client (Cross reference date of progress note when no client signature is present. Progress notes outlines reason.)
  - b. Parent/Guardian (caretaker)
  - c. Specialty Mental Health Provider – SMHP (therapist)
  - d. \*TBS Case Manager/Facilitator
    - i. Co-signatures are required for a trainee and MHRS to complete the plan. Co-signatures must be completed within timelines.
  - e. TBS Coach(s)

**DOCUMENTATION STANDARDS:**

1. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible.
2. A TBS Client Plan is not valid until it is thoroughly completed and final approved with all required signatures.
3. When a client receives TBS services, a copy of the TBS Client Plan should be provided to the Specialty Mental Health Provider (SMHP).
4. The TBS Client Plan should be offered and provided to each team member.

**Area of Need:** Abuse/Addiction Substance/Non-Substance

**Goal:** Increase freedom from abuse/addiction

**Objectives:**

Accept Feedback from Others	Identify Barriers	Learn/Practice Relaxation Techniques
Access Resources/Natural Support in Comm	Identify Behavioral Consequences	Learn/Practice Safe Sex
Address Abuse/Neglect Issues	Identify Irrational Thoughts	Learn/Practice Self-Monitoring
Address Cultural Identity Issues	Identify Medication Side Effects	Learn/Practice Social Skills
Address Gender Identity/Practices Issues	Identify Patterns in Compulsive Behavior	Learn/Practice Symptom Management
Address Outstanding Financial Issues	Identify Personal Strengths	Linkage to PCP or Comm'ty Medical Clinic
Address Outstanding Legal Issues	Identify Physical Health Care Needs	Obtain Medication Services
Address Sexual Issues	Identify Resources/Natural Support in Com	Other
Assessment of Risk	Identify Triggers for Behavior	Participate in Recovery Classes
Attend 12-Step Meetings Regularly	Improve Self Identity/Esteem	Participate in Reunification Plan
Attend Classes	Increase Periods of Abstinence	Reduce Avoidance and Isolation
Complete Treatment as Planned	Learn to Identify Symptoms	Reduce Compulsive/Addictive Behavior
Complete Withdrawal/Detox Phase	Learn/Follow Housing Rules	Reduce Family Stress
Comply with Drug/Alcohol Screens	Learn/Pract Appropriate Emotional Expres	Reduce Frequency/Intensity of Symptoms
Comply with Laws	Learn/Practice Alternative Behaviors	Reduce Hopelessness and Desperation
Develop Artistic/Creative Activities	Learn/Practice Anger Management	Reduce Hospitalization
Develop Coping Skills to Manage Issue(s)	Learn/Practice Communication Skills	Reduce Incarceration
Develop Recreational/Leisure Activities	Learn/Practice Community Living Skills	Reduce Individual Level of Stress
Develop Wellness Recovery Action Plan	Learn/Practice Coping Skills	Reduce Physical Aggression
Develop/Follow Routine or Structure	Learn/Practice Goal Setting	Reduce Risk of Harm
Develop/Practice Personal Safety Skills	Learn/Practice Good Nutrition	Reduce Self-Injurious Behaviors
Develop/Use Relapse Prevention Plan	Learn/Practice Good Sleep Habits	Reduce Social Anxiety
Educate Parent/Guardian	Learn/Practice Healthy Boundaries	Reduce Use of Drugs Including Alcohol
Educate Spouse/Partner	Learn/Practice Healthy Disagreement	Schedule/Attend Neuropsychological Eval
Educate Support System/Family/Friends	Learn/Practice Identifying Needs	Understand Need for Medication
Encourage Connection to PrimaryCare Prov	Learn/Practice Maintaining Friendships	
Engage with Peer Recovery Resources	Learn/Practice Medication Adherence	
Evaluate/Change/Stabilize LivingSituatio	Learn/Practice Money Management	
Expand and Utilize Support System	Learn/Practice Organization and Planning	
Explore Spirituality	Learn/Practice Pers Daily Living Skills	
Identify/Access Community Activities	Learn/Practice Problem Solving Skills	
Identify Alternative Behaviors	Learn/Practice Regular Exercise	

**Area of Need:** Basic Needs – Food, Clothing, Shelter

**Goal:** Meet basic needs

**Objectives:**

Access Resources/Natural Support in Comm  
Address Outstanding Financial Issues  
Address Outstanding Legal Issues  
Adjust to Life-Cycle Transition  
Assess Situation and Identify Needs  
Attend Classes  
Complete Treatment as Planned  
Comply with Laws  
Cooperate with Criminal Justice System  
Develop Coping Skills to Manage Issue(s)  
Develop/Follow Routine or Structure  
Develop/Practice Personal Safety Skills  
Educate Parent/Guardian  
Educate Spouse/Partner  
Educate Support System/Family/Friends  
Engage with Peer Recovery Resources  
Evaluate/Change/Stabilize Living Situatio  
Expand and Utilize Support System  
Identify/Access Community Activities  
Identify Alternative Behaviors  
Identify Barriers  
Identify Behavioral Consequences  
Identify Personal Strengths  
Identify Resources/Natural Support in Com  
Identify Start/Root of Issue  
Interact Appropriately with Others  
Learn/Follow Housing Rules  
Learn/Practice Alternative Behaviors  
Learn/Practice Communication Skills  
Learn/Practice Community Living Skills  
Learn/Practice Coping Skills  
Learn/Practice Goal Setting  
Learn/Practice Good Nutrition  
Learn/Practice Healthy Boundaries  
Learn/Practice Identifying Needs  
Learn/Practice Money Management

Learn/Practice Organization and Planning  
Learn/Practice Pers Daily Living Skills  
Learn/Practice Problem Solving Skills  
Learn/Practice Public Transport Skills  
Learn/Practice Symptom Management  
Obtain Financial Assistance/Benefits  
Other  
Participate in Medical/Dental Treatment  
Participate in Mental Health Treatment  
Provide for Own Food/Clothing/Shelter  
Secure/Hold Stable Employment

**Area of Need:** Education

**Goal:** Improve educational status

**Objectives:**

Accept Feedback from Others  
Access Resources/Natural Support in Comm  
Assess Interests and Abilities  
Assess Situation and Identify Needs  
Attend Classes  
Clarify Educational Needs  
Complete Treatment as Planned  
Develop Coping Skills to Manage Issue(s)  
Develop/Follow Routine or Structure  
Educate Parent/Guardian  
Educate Spouse/Partner  
Educate Support System/Family/Friends  
Engage with Peer Recovery Resources  
Evaluate/Change Education Environment  
Exhibit Appropriate School Behavior  
Expand and Utilize Support System  
Identify/Access Community Activities  
Identify Alternative Behaviors  
Identify Barriers  
Identify Behavioral Consequences  
Identify Issues Regarding Separation  
Identify Personal Strengths  
Identify Resources/Natural Support in Com  
Identify Start/Root of Issue  
Identify Triggers for Behavior  
Identify/Improve Technical Skills  
Improve Self Identity/Esteem  
Interact Appropriately with Others  
Learn to Identify Symptoms  
Learn/Pract Appropriate Emotional Expres  
Learn/Practice Alternative Behaviors  
Learn/Practice Anger Management  
Learn/Practice Communication Skills  
Learn/Practice Coping Skills  
Learn/Practice Goal Setting  
Learn/Practice Good Sleep Habits

Learn/Practice Healthy Boundaries  
Learn/Practice Identifying Needs  
Learn/Practice Maintaining Friendships  
Learn/Practice Medication Adherence  
Learn/Practice Organization and Planning  
Learn/Practice Pers Daily Living Skills  
Learn/Practice Problem Solving Skills  
Learn/Practice Public Transport Skills  
Learn/Practice Relaxation Techniques  
Learn/Practice Self-Monitoring  
Learn/Practice Social Skills  
Learn/Practice Symptom Management  
Other  
Participate in Education/Training Progm  
Reduce Avoidance and Isolation  
Reduce Frequency/Intensity of Symptoms  
Reduce Individual Level of Stress  
Reduce Physical Aggression  
Reduce Reaction to Trauma Triggers  
Reduce Risk of Harm  
Reduce Self-Injurious Behaviors  
Reduce Social Anxiety  
Schedule/Attend Neuropsychological Eval  
Understand Need for Medication

**Area of Need:** Emotional-Behavioral/Psychiatric

**Goal:** Improve/Maintain functioning

**Objectives:**

Accept Feedback from Others	Identify Patterns in Compulsive Behavior	Learn/Practice Safe Sex
Access Resources/Natural Support in Comm	Identify Personal Strengths	Learn/Practice Self-Monitoring
Address Abuse/Neglect Issues	Identify Physical Health Care Needs	Learn/Practice Social Skills
Address Cultural Identity Issues	Identify Resources/Natural Support in Com	Learn/Practice Symptom Management
Address Gender Identity/Practices Issues	Identify Source(s) of Family Conflict	Linkage to PCP or Comm'ty Medical Clinic
Address Sexual Issues	Identify Start/Root of Issue	Obtain Medication Services
Adjust to Life-Cycle Transition	Identify Triggers for Behavior	Other
Assessment of Risk	Identify/Acknowledge Trauma	Participate in Mental Health Treatment
Complete Treatment as Planned	Identify/Obtain Health Insurance	Participate in Recovery Classes
Develop Artistic/Creative Activities	Improve Child-Parent Interactions	Participate in Reunification Plan
Develop Coping Skills to Manage Issue(s)	Improve Family Relationships	Provide for Own Food/Clothing/Shelter
Develop Cultural Identity/Practices	Improve Self Identity/Esteem	Reduce Avoidance and Isolation
Develop Recreational/Leisure Activities	Increase Quality Time in Relationship	Reduce Compulsive/Addictive Behavior
Develop Wellness Recovery Action Plan	Interact Appropriately with Others	Reduce Family Stress
Develop/Follow Routine or Structure	Learn to Identify Symptoms	Reduce Frequency/Intensity of Symptoms
Develop/Practice Personal Safety Skills	Learn/Pract Appropriate Emotional Expres	Reduce Hopelessness and Desperation
Develop/Use Journaling	Learn/Practice Alternative Behaviors	Reduce Hospitalization
Develop/Use Relapse Prevention Plan	Learn/Practice Anger Management	Reduce Incarceration
Educate Parent/Guardian	Learn/Practice Communication Skills	Reduce Individual Level of Stress
Educate Spouse/Partner	Learn/Practice Community Living Skills	Reduce Physical Aggression
Educate Support System/Family/Friends	Learn/Practice Coping Skills	Reduce Reaction to Trauma Triggers
Encourage Connection to PrimaryCare Prov	Learn/Practice Goal Setting	Reduce Risk of Harm
Engage with Peer Recovery Resources	Learn/Practice Good Nutrition	Reduce Self-Injurious Behaviors
Evaluate/Change Education Environment	Learn/Practice Good Sleep Habits	Reduce Social Anxiety
Evaluate/Change Work Environment	Learn/Practice Healthy Boundaries	Reduce Use of Drugs Including Alcohol
Evaluate/Change/Stabilize LivingSituatio	Learn/Practice Healthy Disagreement	Schedule/Attend Neuropsychological Eval
Exhibit Appropriate School Behavior	Learn/Practice Identifying Needs	Understand Need for Medication
Expand and Utilize Support System	Learn/Practice Maintaining Friendships	
Explore Spirituality	Learn/Practice Medication Adherence	
Identify/Access Community Activities	Learn/Practice Organization and Planning	
Identify Alternative Behaviors	Learn/Practice Pain Management	
Identify Barriers	Learn/Practice Pers Daily Living Skills	
Identify Behavioral Consequences	Learn/Practice Problem Solving Skills	
Identify Irrational Thoughts	Learn/Practice Public Transport Skills	
Identify Issues Regarding Separation	Learn/Practice Regular Exercise	
Identify Medication Side Effects	Learn/Practice Relaxation Techniques	

**Area of Need:** Family Stress

**Goal:** Reduce family stress

**Objectives:**

- |  |   |  |
|--|---|--|
| Accept Feedback from Others              | Identify Personal Strengths               | Reduce Avoidance and Isolation         |
| Access Resources/Natural Support in Comm | Identify Physical Health Care Needs       | Reduce Compulsive/Addictive Behavior   |
| Address Abuse/Neglect Issues             | Identify Resources/Natural Support in Com | Reduce Family Stress                   |
| Address Cultural Identity Issues         | Identify Source(s) of Family Conflict     | Reduce Frequency/Intensity of Symptoms |
| Address Gender Identity/Practices Issues | Identify Start/Root of Issue              | Reduce Hospitalization                 |
| Address Outstanding Financial Issues     | Identify Triggers for Behavior            | Reduce Incarceration                   |
| Address Outstanding Legal Issues         | Identify/Acknowledge Trauma               | Reduce Individual Level of Stress      |
| Address Sexual Issues                    | Identify/Obtain Health Insurance          | Reduce Physical Aggression             |
| Adjust to Life-Cycle Transition          | Improve Care Giving Skills                | Reduce Reaction to Trauma Triggers     |
| Assess Situation and Identify Needs      | Improve Child-Parent Interactions         | Reduce Risk of Harm                    |
| Assessment of Risk                       | Improve Family Relationships              | Reduce Self-Injurious Behaviors        |
| Attend 12-Step Meetings Regularly        | Increase Quality Time in Relationship     | Reduce Use of Drugs Including Alcohol  |
| Attend Classes                           | Interact Appropriately with Others        | Secure/Hold Stable Employment          |
| Complete Treatment as Planned            | Learn/Pract Appropriate Emotional Expres  |  |
| Comply with Laws                         | Learn/Practice Acculturation              |  |
| Cooperate with Criminal Justice System   | Learn/Practice Alternative Behaviors      |  |
| Develop Coping Skills to Manage Issue(s) | Learn/Practice Anger Management           |  |
| Develop Cultural Identity/Practices      | Learn/Practice Communication Skills       |  |
| Develop Recreational/Leisure Activities  | Learn/Practice Coping Skills              |  |
| Develop Wellness Recovery Action Plan    | Learn/Practice Goal Setting               |  |
| Develop/Follow Routine or Structure      | Learn/Practice Good Sleep Habits          |  |
| Develop/Practice Personal Safety Skills  | Learn/Practice Healthy Boundaries         |  |
| Develop/Use Journaling                   | Learn/Practice Healthy Disagreement       |  |
| Educate Parent/Guardian                  | Learn/Practice Identifying Needs          |  |
| Educate Spouse/Partner                   | Learn/Practice Medication Adherence       |  |
| Educate Support System/Family/Friends    | Learn/Practice Money Management           |  |
| Engage with Peer Recovery Resources      | Learn/Practice Organization and Planning  |  |
| Evaluate/Change/Stabilize LivingSituatio | Learn/Practice Pers Daily Living Skills   |  |
| Exhibit Appropriate School Behavior      | Learn/Practice Problem Solving Skills     |  |
| Expand and Utilize Support System        | Learn/Practice Relaxation Techniques      |  |
| Explore Spirituality                     | Learn/Practice Self-Monitoring            |  |
| Identify/Access Community Activities     | Learn/Practice Social Skills              |  |
| Identify Alternative Behaviors           | Learn/Practice Symptom Management         |  |
| Identify Barriers                        | Other                                     |  |
| Identify Behavioral Consequences         | Participate in Recovery Classes           |  |
| Identify Issues Regarding Separation     | Participate in Reunification Plan         |  |

**Area of Need:** Financial  
**Goal:** Improve financial situation  
**Objectives:**

Access Resources/Natural Support in Comm  
Address Outstanding Financial Issues  
Address Outstanding Legal Issues  
Assess Situation and Identify Needs  
Assessment of Risk  
Attend 12-Step Meetings Regularly  
Attend Classes  
Clarify Job Dissatisfaction  
Complete Treatment as Planned  
Develop Coping Skills to Manage Issue(s)  
Develop/Follow Routine or Structure  
Educate Parent/Guardian  
Educate Spouse/Partner  
Educate Support System/Family/Friends  
Engage with Peer Recovery Resources  
Evaluate/Change Work Environment  
Evaluate/Change/Stabilize Living Situatio  
Expand and Utilize Support System  
Identify/Access Community Activities  
Identify Alternative Behaviors  
Identify Barriers  
Identify Behavioral Consequences  
Identify Patterns in Compulsive Behavior  
Identify Personal Strengths  
Identify Resources/Natural Support in Com  
Identify Start/Root of Issue  
Learn/Practice Alternative Behaviors  
Learn/Practice Avoiding Impulsivity  
Learn/Practice Communication Skills  
Learn/Practice Coping Skills  
Learn/Practice Goal Setting  
Learn/Practice Healthy Boundaries  
Learn/Practice Healthy Disagreement  
Learn/Practice Identifying Needs  
Learn/Practice Medication Adherence  
Learn/Practice Money Management

Learn/Practice Organization and Planning  
Learn/Practice Problem Solving Skills  
Learn/Practice Self-Monitoring  
Learn/Practice Symptom Management  
Obtain Financial Assistance/Benefits  
Obtain Legal Representation/Services  
Other  
Participate in Mental Health Treatment  
Provide for Own Food/Clothes/Shelter  
Reduce Compulsive/Addictive Behavior  
Reduce Family Stress  
Reduce Individual Level of Stress  
Reduce Risk of Harm  
Reduce Use of Drugs Including Alcohol  
Secure/Hold Stable Employment

**Area of Need:** Identity Issues: Cultural/Gender

**Goal:** Reduce stress of identity issues

**Objectives:**

Access Resources/Natural Support in Comm  
Address Abuse/Neglect Issues  
Address Cultural Identity Issues  
Address Gender Identity/Practices Issues  
Address Sexual Issues  
Adjust to Life-Cycle Transition  
Complete Treatment as Planned  
Develop Artistic/Creative Activities  
Develop Coping Skills to Manage Issue(s)  
Develop Recreational/Leisure Activities  
Develop/Practice Personal Safety Skills  
Educate Parent/Guardian  
Educate Spouse/Partner  
Educate Support System/Family/Friends  
Engage with Peer Recovery Resources  
Evaluate/Change Work Environment  
Evaluate/Change/Stabilize Living Situation  
Exhibit Appropriate School Behavior  
Expand and Utilize Support System  
Explore Spirituality  
Identify/Access Community Activities  
Identify Alternative Behaviors  
Identify Barriers  
Identify Behavioral Consequences  
Identify Personal Strengths  
Identify Resources/Natural Support in Comm  
Identify Source(s) of Family Conflict  
Identify/Acknowledge Trauma  
Improve Care Giving Skills  
Improve Self Identity/Esteem  
Learn/Pract Appropriate Emotional Expressions  
Learn/Practice Alternative Behaviors  
Learn/Practice Communication Skills  
Learn/Practice Coping Skills  
Learn/Practice Goal Setting  
Learn/Practice Healthy Boundaries

Learn/Practice Healthy Disagreement  
Learn/Practice Identifying Needs  
Learn/Practice Maintaining Friendships  
Learn/Practice Medication Adherence  
Learn/Practice Problem Solving Skills  
Learn/Practice Safe Sex  
Learn/Practice Social Skills  
Learn/Practice Symptom Management  
Other  
Reduce Avoidance and Isolation  
Reduce Compulsive/Addictive Behavior  
Reduce Individual Level of Stress  
Reduce Self-Injurious Behaviors  
Reduce Social Anxiety  
Reduce Use of Drugs Including Alcohol  
Understand Need for Medication

**Area of Need:** Intimate Relationships

**Goal:** Improve intimate relationships

**Objectives:**

Accept Feedback from Others  
Access Resources/Natural Support in Comm  
Address Abuse/Neglect Issues  
Address Cultural Identity Issues  
Address Gender Identity/Practices Issues  
Address Outstanding Financial Issues  
Address Outstanding Legal Issues  
Address Sexual Issues  
Adjust to Life-Cycle Transition  
Assess Situation and Identify Needs  
Assessment of Risk  
Attend 12-Step Meetings Regularly  
Complete Treatment as Planned  
Comply with Laws  
Cooperate with Criminal Justice System  
Develop Coping Skills to Manage Issue(s)  
Develop Recreational/Leisure Activities  
Develop/Follow Routine or Structure  
Develop/Practice Personal Safety Skills  
Educate Parent/Guardian  
Educate Spouse/Partner  
Educate Support System/Family/Friends  
Engage with Peer Recovery Resources  
Expand and Utilize Support System  
Explore Spirituality  
Identify/Access Community Activities  
Identify Alternative Behaviors  
Identify Barriers  
Identify Behavioral Consequences  
Identify Issues Regarding Separation  
Identify Personal Strengths  
Identify Resources/Natural Support in Com  
Identify Source(s) of Family Conflict  
Identify Start/Root of Issue  
Identify Triggers for Behavior  
Identify/Acknowledge Trauma

Improve Care Giving Skills  
Improve Child-Parent Interactions  
Improve Family Relationships  
Improve Self Identity/Esteem  
Increase Quality Time in Relationship  
Interact Appropriately with Others  
Learn/Pract Appropriate Emotional Expres  
Learn/Practice Alternative Behaviors  
Learn/Practice Anger Management  
Learn/Practice Communication Skills  
Learn/Practice Coping Skills  
Learn/Practice Goal Setting  
Learn/Practice Healthy Boundaries  
Learn/Practice Healthy Disagreement  
Learn/Practice Identifying Needs  
Learn/Practice Maintaining Friendships  
Learn/Practice Medication Adherence  
Learn/Practice Money Management  
Learn/Practice Organization and Planning  
Learn/Practice Problem Solving Skills  
Learn/Practice Safe Sex  
Learn/Practice Self-Monitoring  
Learn/Practice Social Skills  
Learn/Practice Symptom Management  
Other  
Participate in Reunification Plan  
Reduce Avoidance and Isolation  
Reduce Compulsive/Addictive Behavior  
Reduce Family Stress  
Reduce Frequency/Intensity of Symptoms  
Reduce Hopelessness and Desperation  
Reduce Individual Level of Stress  
Reduce Physical Aggression  
Reduce Reaction to Trauma Triggers  
Reduce Risk of Harm  
Reduce Self-Injurious Behaviors

Reduce Social Anxiety  
Reduce Use of Drugs Including Alcohol  
Secure/Hold Stable Employment  
Understand Need for Medication

**Area of Need:** Lack of Physical Health Care

**Goal:** Obtain physical health care

**Objectives:**

Access Resources/Natural Support in Comm  
Address Outstanding Financial Issues  
Adjust to Life-Cycle Transition  
Assessment of Risk  
Complete Physical Exam and/or Lab Work  
Complete Treatment as Planned  
Develop Coping Skills to Manage Issue(s)  
Educate Parent/Guardian  
Educate Spouse/Partner  
Educate Support System/Family/Friends  
Encourage Connection to PrimaryCare Prov  
Engage with Peer Recovery Resources  
Expand and Utilize Support System  
Identify/Access Community Activities  
Identify Barriers  
Identify Physical Health Care Needs  
Identify Resources/Natural Support in Com  
Identify/Obtain Health Insurance  
Learn/Practice Communication Skills  
Learn/Practice Coping Skills  
Learn/Practice Goal Setting  
Learn/Practice Identifying Needs  
Learn/Practice Problem Solving Skills  
Learn/Practice Public Transport Skills  
Linkage to PCP or Comm'ty Medical Clinic  
Obtain Medical/Dental Exam  
Obtain Medication Services  
Other  
Reduce Family Stress  
Reduce Individual Level of Stress  
Reduce Risk of Harm

**Area of Need:** Legal  
**Goal:** Fulfill legal obligations  
**Objectives:**

Accept Feedback from Others  
Access Resources/Natural Support in Comm  
Address Outstanding Financial Issues  
Address Outstanding Legal Issues  
Assess Situation and Identify Needs  
Assessment of Risk  
Complete Treatment as Planned  
Comply with Drug/Alcohol Screens  
Comply with Laws  
Cooperate with Criminal Justice System  
Develop Coping Skills to Manage Issue(s)  
Develop/Follow Routine or Structure  
Educate Parent/Guardian  
Educate Spouse/Partner  
Educate Support System/Family/Friends  
Engage with Peer Recovery Resources  
Expand and Utilize Support System  
Identify/Access Community Activities  
Identify Alternative Behaviors  
Identify Barriers  
Identify Behavioral Consequences  
Identify Patterns in Compulsive Behavior  
Identify Personal Strengths  
Identify Resources/Natural Support in Com  
Identify Triggers for Behavior  
Learn/Pract Appropriate Emotional Expres  
Learn/Practice Alternative Behaviors  
Learn/Practice Anger Management  
Learn/Practice Avoiding Impulsivity  
Learn/Practice Communication Skills  
Learn/Practice Coping Skills  
Learn/Practice Goal Setting  
Learn/Practice Healthy Disagreement  
Learn/Practice Identifying Needs  
Learn/Practice Medication Adherence  
Learn/Practice Money Management

Learn/Practice Organization and Planning  
Learn/Practice Problem Solving Skills  
Learn/Practice Self-Monitoring  
Learn/Practice Social Skills  
Learn/Practice Symptom Management  
Obtain Legal Representation/Services  
Other  
Reduce Family Stress  
Reduce Frequency/Intensity of Symptoms  
Reduce Hopelessness and Desperation  
Reduce Incarceration  
Reduce Individual Level of Stress  
Reduce Physical Aggression  
Reduce Risk of Harm  
Reduce Use of Drugs Including Alcohol

**Area of Need:** Meaningful Role (tied to self-determination)

**Goal:** Increase self-determination

**Objectives:**

Accept Feedback from Others  
Access Resources/Natural Support in Comm  
Address Abuse/Neglect Issues  
Address Cultural Identity Issues  
Address Gender Identity/Practices Issues  
Address Sexual Issues  
Adjust to Life-Cycle Transition  
Assess Interests and Abilities  
Assess Situation and Identify Needs  
Clarify Educational Needs  
Clarify Job Dissatisfaction  
Complete Treatment as Planned  
Comply with Laws  
Develop Artistic/Creative Activities  
Develop Coping Skills to Manage Issue(s)  
Develop Recreational/Leisure Activities  
Develop Wellness Recovery Action Plan  
Educate Parent/Guardian  
Educate Spouse/Partner  
Educate Support System/Family/Friends  
Engage with Peer Recovery Resources  
Evaluate/Change Education Environment  
Evaluate/Change Work Environment  
Evaluate/Change/Stabilize Living Situatio  
Expand and Utilize Support System  
Explore Spirituality  
Identify/Access Community Activities  
Identify Alternative Behaviors  
Identify Barriers  
Identify Behavioral Consequences  
Identify Personal Strengths  
Identify Resources/Natural Support in Com  
Identify Start/Root of Issue  
Identify/Acknowledge Trauma  
Identify/Improve Technical Skills  
Improve Self Identity/Esteem

Increase Quality Time in Relationship  
Learn/Practice Community Living Skills  
Learn/Practice Coping Skills  
Learn/Practice Goal Setting  
Learn/Practice Healthy Boundaries  
Learn/Practice Healthy Disagreement  
Learn/Practice Identifying Needs  
Learn/Practice Job Skills  
Learn/Practice Medication Adherence  
Learn/Practice Pers Daily Living Skills  
Learn/Practice Problem Solving Skills  
Learn/Practice Regular Exercise  
Learn/Practice Relaxation Techniques  
Learn/Practice Self-Monitoring  
Learn/Practice Symptom Management  
Other  
Participate in Education/Training Progrm  
Reduce Avoidance and Isolation  
Reduce Frequency/Intensity of Symptoms  
Reduce Hospitalization  
Reduce Incarceration  
Reduce Use of Drugs Including Alcohol  
Secure/Hold Stable Employment

**Area of Need:** Neglect/Abuse

**Goal:** Reduce threat to safety

**Objectives:**

Access Resources/Natural Support in Comm  
Address Abuse/Neglect Issues  
Address Cultural Identity Issues  
Address Gender Identity/Practices Issues  
Address Sexual Issues  
Adjust to Life-Cycle Transition  
Assess Situation and Identify Needs  
Assessment of Risk  
Attend Classes  
Complete Physical Exam and/or Lab Work  
Complete Treatment as Planned  
Comply with Laws  
Cooperate with Criminal Justice System  
Develop Coping Skills to Manage Issue(s)  
Develop Wellness Recovery Action Plan  
Develop/Follow Routine or Structure  
Develop/Practice Personal Safety Skills  
Educate Parent/Guardian  
Educate Spouse/Partner  
Educate Support System/Family/Friends  
Engage with Peer Recovery Resources  
Evaluate/Change/Stabilize Living Situatio  
Exhibit Appropriate School Behavior  
Expand and Utilize Support System  
Identify/Access Community Activities  
Identify Alternative Behaviors  
Identify Barriers  
Identify Behavioral Consequences  
Identify Issues Regarding Separation  
Identify Personal Strengths  
Identify Resources/Natural Support in Com  
Identify Source(s) of Family Conflict  
Identify Start/Root of Issue  
Identify Triggers for Behavior  
Identify/Acknowledge Trauma  
Improve Care Giving Skills

Improve Child-Parent Interactions  
Improve Family Relationships  
Interact Appropriately with Others  
Learn/Follow Housing Rules  
Learn/Pract Appropriate Emotional Expres  
Learn/Practice Alternative Behaviors  
Learn/Practice Anger Management  
Learn/Practice Communication Skills  
Learn/Practice Community Living Skills  
Learn/Practice Coping Skills  
Learn/Practice Goal Setting  
Learn/Practice Healthy Boundaries  
Learn/Practice Healthy Disagreement  
Learn/Practice Identifying Needs  
Learn/Practice Medication Adherence  
Learn/Practice Problem Solving Skills  
Learn/Practice Safe Sex  
Learn/Practice Self-Monitoring  
Learn/Practice Symptom Management  
Other  
Participate in Recovery Classes  
Participate in Reunification Plan  
Reduce Family Stress  
Reduce Frequency/Intensity of Symptoms  
Reduce Hospitalization  
Reduce Incarceration  
Reduce Individual Level of Stress  
Reduce Physical Aggression  
Reduce Risk of Harm  
Reduce Self-Injurious Behaviors  
Reduce Use of Drugs Including Alcohol  
Understand Need for Medication

**Area of Need:** Neurological/Brain Impairment

**Goal:** Improve daily functioning

**Objectives:**

Accept Feedback from Others	Learn/Pract Appropriate Emotional Express	Reduce Physical Aggression
Access Resources/Natural Support in Comm	Learn/Practice Alternative Behaviors	Reduce Risk of Harm
Address Cultural Identity Issues	Learn/Practice Anger Management	Reduce Self-Injurious Behaviors
Address Outstanding Legal Issues	Learn/Practice Communication Skills	Reduce Social Anxiety
Address Sexual Issues	Learn/Practice Community Living Skills	Reduce Use of Drugs Including Alcohol
Adjust to Life-Cycle Transition	Learn/Practice Coping Skills	Schedule/Attend Neuropsychological Eval
Attend Classes	Learn/Practice Goal Setting	Understand Need for Medication
Complete Treatment as Planned	Learn/Practice Good Nutrition	
Develop Artistic/Creative Activities	Learn/Practice Good Sleep Habits	
Develop Coping Skills to Manage Issue(s)	Learn/Practice Healthy Boundaries	
Develop Recreational/Leisure Activities	Learn/Practice Healthy Disagreement	
Develop Wellness Recovery Action Plan	Learn/Practice Identifying Needs	
Develop/Follow Routine or Structure	Learn/Practice Maintaining Friendships	
Develop/Practice Personal Safety Skills	Learn/Practice Medication Adherence	
Educate Parent/Guardian	Learn/Practice Money Management	
Educate Spouse/Partner	Learn/Practice Organization and Planning	
Educate Support System/Family/Friends	Learn/Practice Pers Daily Living Skills	
Encourage Connection to PrimaryCare Prov	Learn/Practice Problem Solving Skills	
Engage with Peer Recovery Resources	Learn/Practice Public Transport Skills	
Exhibit Appropriate School Behavior	Learn/Practice Regular Exercise	
Expand and Utilize Support System	Learn/Practice Relaxation Techniques	
Identify/Access Community Activities	Learn/Practice Safe Sex	
Identify Alternative Behaviors	Learn/Practice Self-Monitoring	
Identify Barriers	Learn/Practice Social Skills	
Identify Behavioral Consequences	Learn/Practice Symptom Management	
Identify Medication Side Effects	Linkage to PCP or Comm'ty Medical Clinic	
Identify Personal Strengths	Other	
Identify Physical Health Care Needs	Participate in Mental Health Treatment	
Identify Resources/Natural Support in Com	Participate in Recovery Classes	
Identify Start/Root of Issue	Provide for Own Food/Clothing/Shelter	
Identify Triggers for Behavior	Reduce Avoidance and Isolation	
Improve Child-Parent Interactions	Reduce Compulsive/Addictive Behavior	
Increase Quality Time in Relationship	Reduce Frequency/Intensity of Symptoms	
Interact Appropriately with Others	Reduce Hospitalization	
Learn to Identify Symptoms	Reduce Incarceration	
Learn/Follow Housing Rules	Reduce Individual Level of Stress	

**Area of Need:** Physical Health Problems

**Goal:** Improve physical health

**Objectives:**

Access Resources/Natural Support in Comm  
Address Cultural Identity Issues  
Address Gender Identity/Practices Issues  
Address Outstanding Financial Issues  
Address Sexual Issues  
Adjust to Life-Cycle Transition  
Assessment of Risk  
Attend Classes  
Complete Physical Exam and/or Lab Work  
Complete Treatment as Planned  
Develop Coping Skills to Manage Issue(s)  
Develop Recreational/Leisure Activities  
Develop Wellness Recovery Action Plan  
Develop/Follow Routine or Structure  
Develop/Use Relapse Prevention Plan  
Educate Parent/Guardian  
Educate Spouse/Partner  
Educate Support System/Family/Friends  
Encourage Connection to PrimaryCare Prov  
Engage with Peer Recovery Resources  
Expand and Utilize Support System  
Identify/Access Community Activities  
Identify Alternative Behaviors  
Identify Barriers  
Identify Behavioral Consequences  
Identify Medication Side Effects  
Identify Patterns in Compulsive Behavior  
Identify Personal Strengths  
Identify Physical Health Care Needs  
Identify Resources/Natural Support in Com  
Identify Start/Root of Issue  
Identify Triggers for Behavior  
Identify/Obtain Health Insurance  
Learn to Identify Symptoms  
Learn/Practice Alternative Behaviors  
Learn/Practice Communication Skills

Learn/Practice Coping Skills  
Learn/Practice Goal Setting  
Learn/Practice Good Nutrition  
Learn/Practice Good Sleep Habits  
Learn/Practice Identifying Needs  
Learn/Practice Medication Adherence  
Learn/Practice Pain Management  
Learn/Practice Pers Daily Living Skills  
Learn/Practice Problem Solving Skills  
Learn/Practice Regular Exercise  
Learn/Practice Relaxation Techniques  
Learn/Practice Safe Sex  
Learn/Practice Self-Monitoring  
Learn/Practice Symptom Management  
Linkage to PCP or Comm'ty Medical Clinic  
Obtain Medical/Dental Exam  
Obtain Medication Services  
Other  
Participate in Medical/Dental Treatment  
Reduce Compulsive/Addictive Behavior  
Reduce Frequency/Intensity of Symptoms  
Reduce Hospitalization  
Reduce Individual Level of Stress  
Reduce Risk of Harm  
Reduce Self-Injurious Behaviors  
Reduce Use of Drugs Including Alcohol  
Schedule/Attend Neuropsychological Eval  
Understand Need for Medication

**Area of Need:** Potential for Harm Self/Others

**Goal:** Reduce potential for harm

**Objectives:**

Accept Feedback from Others  
Access Resources/Natural Support in Comm  
Address Abuse/Neglect Issues  
Address Sexual Issues  
Assessment of Risk  
Attend Classes  
Complete Physical Exam and/or Lab Work  
Complete Treatment as Planned  
Cooperate with Criminal Justice System  
Develop Coping Skills to Manage Issue(s)  
Develop Wellness Recovery Action Plan  
Develop/Follow Routine or Structure  
Develop/Practice Personal Safety Skills  
Educate Parent/Guardian  
Educate Spouse/Partner  
Educate Support System/Family/Friends  
Engage with Peer Recovery Resources  
Evaluate/Change/Stabilize Living Situation  
Expand and Utilize Support System  
Identify/Access Community Activities  
Identify Alternative Behaviors  
Identify Barriers  
Identify Behavioral Consequences  
Identify Personal Strengths  
Identify Resources/Natural Support in Comm  
Identify Source(s) of Family Conflict  
Identify/Acknowledge Trauma  
Improve Care Giving Skills  
Improve Child-Parent Interactions  
Improve Family Relationships  
Learn to Identify Symptoms  
Learn/Pract Appropriate Emotional Expressions  
Learn/Practice Alternative Behaviors  
Learn/Practice Anger Management  
Learn/Practice Communication Skills  
Learn/Practice Community Living Skills

Learn/Practice Coping Skills  
Learn/Practice Goal Setting  
Learn/Practice Good Sleep Habits  
Learn/Practice Healthy Boundaries  
Learn/Practice Healthy Disagreement  
Learn/Practice Identifying Needs  
Learn/Practice Medication Adherence  
Learn/Practice Pers Daily Living Skills  
Learn/Practice Problem Solving Skills  
Learn/Practice Regular Exercise  
Learn/Practice Relaxation Techniques  
Learn/Practice Safe Sex  
Learn/Practice Self-Monitoring  
Learn/Practice Symptom Management  
Other  
Participate in Education/Training Program  
Participate in Mental Health Treatment  
Participate in Reunification Plan  
Reduce Compulsive/Addictive Behavior  
Reduce Family Stress  
Reduce Frequency/Intensity of Symptoms  
Reduce Hospitalization  
Reduce Incarceration  
Reduce Individual Level of Stress  
Reduce Physical Aggression  
Reduce Risk of Harm  
Reduce Self-Injurious Behaviors  
Reduce Use of Drugs Including Alcohol  
Understand Need for Medication

**Area of Need:** Social Functioning

**Goal:** Improve social functioning

**Objectives:**

Accept Feedback from Others	Identify Medication Side Effects	Learn/Practice Self-Monitoring
Access Resources/Natural Support in Comm	Identify Personal Strengths	Learn/Practice Social Skills
Address Abuse/Neglect Issues	Identify Resources/Natural Support in Com	Learn/Practice Symptom Management
Address Cultural Identity Issues	Identify Source(s) of Family Conflict	Other
Address Gender Identity/Practices Issues	Identify Start/Root of Issue	Participate in Education/Training Progrm
Address Outstanding Financial Issues	Identify Triggers for Behavior	Participate in Mental Health Treatment
Address Sexual Issues	Identify/Acknowledge Trauma	Participate in Recovery Classes
Adjust to Life-Cycle Transition	Improve Care Giving Skills	Participate in Reunification Plan
Assess Interests and Abilities	Improve Child-Parent Interactions	Reduce Avoidance and Isolation
Assess Situation and Identify Needs	Improve Family Relationships	Reduce Compulsive/Addictive Behavior
Assessment of Risk	Improve Self Identity/Esteem	Reduce Family Stress
Attend Classes	Increase Quality Time in Relationship	Reduce Frequency/Intensity of Symptoms
Complete Treatment as Planned	Interact Appropriately with Others	Reduce Hospitalization
Develop Artistic/Creative Activities	Learn to Identify Symptoms	Reduce Incarceration
Develop Coping Skills to Manage Issue(s)	Learn/Follow Housing Rules	Reduce Individual Level of Stress
Develop Cultural Identity/Practices	Learn/Pract Appropriate Emotional Expres	Reduce Physical Aggression
Develop Recreational/Leisure Activities	Learn/Practice Acculturation	Reduce Risk of Harm
Develop Wellness Recovery Action Plan	Learn/Practice Alternative Behaviors	Reduce Self-Injurious Behaviors
Develop/Follow Routine or Structure	Learn/Practice Anger Management	Reduce Social Anxiety
Develop/Practice Personal Safety Skills	Learn/Practice Communication Skills	Reduce Use of Drugs Including Alcohol
Educate Parent/Guardian	Learn/Practice Community Living Skills	Understand Need for Medication
Educate Spouse/Partner	Learn/Practice Coping Skills	
Educate Support System/Family/Friends	Learn/Practice Goal Setting	
Engage with Peer Recovery Resources	Learn/Practice Good Sleep Habits	
Evaluate/Change Education Environment	Learn/Practice Healthy Boundaries	
Evaluate/Change Work Environment	Learn/Practice Healthy Disagreement	
Evaluate/Change/Stabilize LivingSituatio	Learn/Practice Identifying Needs	
Exhibit Appropriate School Behavior	Learn/Practice Maintaining Friendships	
Expand and Utilize Support System	Learn/Practice Medication Adherence	
Explore Spirituality	Learn/Practice Organization and Planning	
Identify/Access Community Activities	Learn/Practice Pers Daily Living Skills	
Identify Alternative Behaviors	Learn/Practice Problem Solving Skills	
Identify Barriers	Learn/Practice Public Transport Skills	
Identify Behavioral Consequences	Learn/Practice Regular Exercise	
Identify Irrational Thoughts	Learn/Practice Relaxation Techniques	
Identify Issues Regarding Separation	Learn/Practice Safe Sex	

**Area of Need:** Spiritual  
**Goal:** Increase inner peace  
**Objectives:**

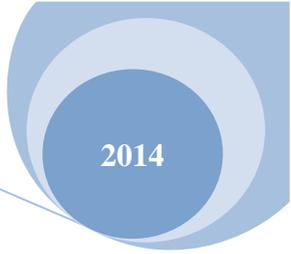
Accept Feedback from Others	Learn to Identify Symptoms
Access Resources/Natural Support in Comm	Learn/Pract Appropriate Emotional Expres
Address Cultural Identity Issues	Learn/Practice Alternative Behaviors
Address Gender Identity/Practices Issues	Learn/Practice Anger Management
Address Outstanding Financial Issues	Learn/Practice Communication Skills
Address Outstanding Legal Issues	Learn/Practice Coping Skills
Address Sexual Issues	Learn/Practice Goal Setting
Adjust to Life-Cycle Transition	Learn/Practice Healthy Disagreement
Attend Classes	Learn/Practice Identifying Needs
Complete Treatment as Planned	Learn/Practice Maintaining Friendships
Develop Artistic/Creative Activities	Learn/Practice Medication Adherence
Develop Coping Skills to Manage Issue(s)	Learn/Practice Organization and Planning
Develop Recreational/Leisure Activities	Learn/Practice Problem Solving Skills
Develop/Follow Routine or Structure	Learn/Practice Regular Exercise
Develop/Practice Personal Safety Skills	Learn/Practice Relaxation Techniques
Develop/Use Journaling	Learn/Practice Self-Monitoring
Educate Parent/Guardian	Learn/Practice Symptom Management
Educate Spouse/Partner	Other
Educate Support System/Family/Friends	Participate in Reunification Plan
Engage with Peer Recovery Resources	Reduce Avoidance and Isolation
Exhibit Appropriate School Behavior	Reduce Compulsive/Addictive Behavior
Expand and Utilize Support System	Reduce Family Stress
Explore Spirituality	Reduce Frequency/Intensity of Symptoms
Identify/Access Community Activities	Reduce Hospitalization
Identify Alternative Behaviors	Reduce Incarceration
Identify Barriers	Reduce Individual Level of Stress
Identify Behavioral Consequences	Reduce Physical Aggression
Identify Personal Strengths	Reduce Reaction to Trauma Triggers
Identify Resources/Natural Support in Com	Reduce Risk of Harm
Identify Source(s) of Family Conflict	Reduce Self-Injurious Behaviors
Identify Start/Root of Issue	Reduce Social Anxiety
Identify Triggers for Behavior	Understand Need for Medication
Identify/Acknowledge Trauma	
Improve Self Identity/Esteem	
Increase Quality Time in Relationship	
Interact Appropriately with Others	

**Area of Need: Stress**

**Goal: Reduce Stress**

**Objectives:**

Accept Feedback from Others	Identify/Access Community Activities	Learn/Practice Maintaining Friendships
Access Resources/Natural Support in Comm	Identify Alternative Behaviors	Learn/Practice Medication Adherence
Address Abuse/Neglect Issues	Identify Barriers	Learn/Practice Money Management
Address Cultural Identity Issues	Identify Behavioral Consequences	Learn/Practice Organization and Planning
Address Gender Identity/Practices Issues	Identify Issues Regarding Separation	Learn/Practice Pers Daily Living Skills
Address Outstanding Financial Issues	Identify Personal Strengths	Learn/Practice Problem Solving Skills
Address Outstanding Legal Issues	Identify Physical Health Care Needs	Learn/Practice Regular Exercise
Address Sexual Issues	Identify Resources/Natural Support in Com	Learn/Practice Relaxation Techniques
Adjust to Life-Cycle Transition	Identify Source(s) of Family Conflict	Learn/Practice Safe Sex
Assessment of Risk	Identify Triggers for Behavior	Learn/Practice Self-Monitoring
Attend Classes	Identify/Acknowledge Trauma	Learn/Practice Social Skills
Clarify Job Dissatisfaction	Identify/Improve Technical Skills	Learn/Practice Symptom Management
Complete Physical Exam and/or Lab Work	Improve Care Giving Skills	Linkage to PCP or Comm'ty Medical Clinic
Complete Treatment as Planned	Improve Child-Parent Interactions	Other
Cooperate with Criminal Justice System	Improve Family Relationships	Participate in Mental Health Treatment
Develop Artistic/Creative Activities	Improve Self Identity/Esteem	Participate in Recovery Classes
Develop Coping Skills to Manage Issue(s)	Increase Quality Time in Relationship	Participate in Reunification Plan
Develop Recreational/Leisure Activities	Interact Appropriately with Others	Reduce Avoidance and Isolation
Develop Wellness Recovery Action Plan	Learn to Identify Symptoms	Reduce Compulsive/Addictive Behavior
Develop/Follow Routine or Structure	Learn/Follow Housing Rules	Reduce Family Stress
Develop/Practice Personal Safety Skills	Learn/Pract Appropriate Emotional Expres	Reduce Frequency/Intensity of Symptoms
Educate Parent/Guardian	Learn/Practice Alternative Behaviors	Reduce Hospitalization
Educate Spouse/Partner	Learn/Practice Anger Management	Reduce Incarceration
Educate Support System/Family/Friends	Learn/Practice Communication Skills	Reduce Individual Level of Stress
Encourage Connection to PrimaryCare Prov	Learn/Practice Community Living Skills	Reduce Physical Aggression
Engage with Peer Recovery Resources	Learn/Practice Coping Skills	Reduce Reaction to Trauma Triggers
Evaluate/Change Education Environment	Learn/Practice Goal Setting	Reduce Risk of Harm
Evaluate/Change Work Environment	Learn/Practice Good Nutrition	Reduce Self-Injurious Behaviors
Evaluate/Change/Stabilize LivingSituatio	Learn/Practice Good Sleep Habits	Reduce Social Anxiety
Exhibit Appropriate School Behavior	Learn/Practice Healthy Boundaries	Reduce Use of Drugs Including Alcohol
Expand and Utilize Support System	Learn/Practice Healthy Disagreement	Secure/Hold Stable Employment
Explore Spirituality	Learn/Practice Identifying Needs	Understand Need for Medication



- WHEN:** Used when completing Client Plans to assist with menu choices
- ON WHOM:** All clients for whom a client plan is required.
- UTILIZED BY:** Clinicians completing the client plan
- MODE OF USE:** Used as a resource to make it easier to select tiers for the plan.
- NOTE:** Clinicians are reminded to individualize each tier selected for the client. See each page to find the correct Need, Goal, and Objective choices.

**Area of Need: Trauma**

**Goal:** Reduce effects of trauma

**Objectives:**

Accept Feedback from Others  
Access Resources/Natural Support in Comm  
Address Abuse/Neglect Issues  
Address Cultural Identity Issues  
Address Gender Identity/Practices Issues  
Address Sexual Issues  
Assessment of Risk  
Attend Classes  
Complete Physical Exam and/or Lab Work  
Complete Treatment as Planned  
Develop Coping Skills to Manage Issue(s)  
Develop Wellness Recovery Action Plan  
Develop/Follow Routine or Structure  
Develop/Practice Personal Safety Skills  
Educate Parent/Guardian  
Educate Spouse/Partner  
Educate Support System/Family/Friends  
Engage with Peer Recovery Resources  
Expand and Utilize Support System  
Explore Spirituality  
Identify/Access Community Activities  
Identify Alternative Behaviors  
Identify Barriers  
Identify Behavioral Consequences  
Identify Irrational Thoughts  
Identify Issues Regarding Separation  
Identify Patterns in Compulsive Behaviors  
Identify Personal Strengths  
Identify Physical Health Care Needs  
Identify Resources/Natural Support in Com  
Identify Source(s) of Family Conflict  
Identify Triggers for Behavior

Identify/Acknowledge Trauma  
Improve Care Giving Skills  
Improve Child-Parent Interactions  
Improve Family Relationships  
Improve Self Identity/Esteem  
Interact Appropriately with Others  
Learn to Identify Symptoms  
Learn/Pract Appropriate Emotional Expres  
Learn/Practice Alternative Behaviors  
Learn/Practice Anger Management  
Learn/Practice Communication Skills  
Learn/Practice Coping Skills  
Learn/Practice Goal Setting  
Learn/Practice Healthy Boundaries  
Learn/Practice Healthy Disagreement  
Learn/Practice Identifying Needs  
Learn/Practice Maintaining Friendships  
Learn/Practice Medication Adherence  
Learn/Practice Problem Solving Skills  
Learn/Practice Relaxation Techniques  
Learn/Practice Self-Monitoring  
Learn/Practice Symptom Management  
Other  
Participate in Reunification Plan  
Reduce Avoidance and Isolation  
Reduce Compulsive/Addictive Behavior  
Reduce Family Stress  
Reduce Frequency/Intensity of Symptoms  
Reduce Hospitalization  
Reduce Incarceration  
Reduce Individual Level of Stress  
Reduce Physical Aggression

Reduce Reaction to Trauma Triggers  
Reduce Risk of Harm  
Reduce Self-Injurious Behaviors  
Reduce Social Anxiety  
Reduce Use of Drugs Including Alcohol  
Schedule/Attend Neuropsychological Eval  
Understand Need for Medication

**Area of Need:** Vocational/Employment

**Goal:** Improve vocational status

**Objectives:**

Accept Feedback from Others  
Access Resources/Natural Support in Comm  
Address Outstanding Financial Issues  
Adjust to Life-Cycle Transition  
Attend Classes  
Clarify Educational Needs  
Clarify Jon Dissatisfaction  
Complete Treatment as Planned  
Develop Coping Skills to Manage Issue(s)  
Develop/Follow Routine or Structure  
Educate Parent/Guardian  
Educate Spouse/Partner  
Educate Support System/Family/Friends  
Engage with Peer Recovery Resources  
Evaluate/Change Education Environment  
Evaluate/Change Work Environment  
Exhibit appropriate School Behavior  
Expand and Utilize Support System  
Identify/Access Community Activities  
Identify Alternative Behaviors  
Identify Barriers  
Identify Behavioral Consequences  
Identify Personal Strengths  
Identify Recourses/NaturalSupport in Com  
Identify/Improve Technical Skills  
Learn/Pract Appropriate Emotioanl Expres  
Learn/Practice Alternative Behaviors  
Learn/Practice Anger Management  
Learn/Practice Communication Skills  
Learn/Practice Coping Skills  
Learn/Practice Goal Setting  
Learn/Practice Good Sleep Habits

Learn/Practice Healthy Boundaries  
Learn/Practice Healthy Disagreement  
Learn/Practice Identifying Needs  
Learn/Practice Job Skills  
Learn/Practice Medication Adherence  
Learn/Practice Money Management  
Learn/Practice Organization and Planning  
Learn/Practice Pers Daily Living Skills  
Learn/Practice Problem Solving Skills  
Learn/Practice Transport Skills  
Learn/Practice Self-Monitoring  
Learn/Practice Social Skills  
Learn/Practice Symptom Management  
Other  
Participate in Education/Training Program  
Reduce Frequency/Intensity of Symptoms  
Reduce Individual Level of Stress  
Reduce Physical Aggression  
Reduce Social Anxiety  
Reduce Use of Drugs Including Alcohol  
Secure/Hold Stable Employment  
Understand Need for Medication

# PROGRESS NOTES

## Section 5

**San Diego County Mental Health Services**  
**DAY TREATMENT WEEKLY PROGRESS NOTE**  
**Instructions**

**CLIENT NAME:** Required Field

**CLIENT #:** Enter CCBH assigned number

**PROGRAM NAME:** Required Field

**SERVICE CODE 95:** Circle correct program: DRF: Day Rehab Full, DRH: Day Rehab Half, DIF: Day Intensive Full, DIH: Day Intensive Half

**UNIT/SUBUNIT:** Required Field

**DIAGNOSIS:** Enter ICD-10 Code and Description

**SERVICE COMPONENTS: Only mark the corresponding boxes when client attends the services**

*Monday-Friday:* Required to include specific dates including year for each day

*Individual Therapy:* Mark the box that corresponds with the date the client attended Individual Therapy. The Individual Psychotherapy notes may be done on a separate progress note and indicate “See note dated \_\_/\_\_/\_\_” in the Significant Weekly Information section and file with the Weekly.

*Family Therapy:* Mark the box that corresponds with the date that client received Family Therapy if applicable. This box is for a therapeutic service, collateral contact can be documented within Significant Weekly Information or Other Interventions section. If a separate note is completed, can indicate “see Family Therapy note dated \_\_/\_\_/\_\_” in the Family Therapy section and file with the Weekly.

*Group Therapy:* Mark the box that corresponds with the date that client attended Group Psychotherapy. Group Therapy may be documented in the body of the Weekly, or it can be documented on a separate Group Psychotherapy progress note and indicate “See note dated \_\_/\_\_/\_\_” in the Significant Weekly Information section and file with the Weekly.

*Therapeutic Milieu:* Mark the box that corresponds with the date that client was billable for participating in Day Program milieu. If less than 50%, this box should not be marked.

*Community Meeting:* Mark the box that corresponds with the date that client attended Community Meeting.

**ATTENDANCE TIME:** Must enter total attendance time for the each day. This time should equal the corresponding Sign In/Out sheets utilized to track attendance time and should be reflected in the billed time to Medi-cal.

**San Diego County Mental Health Services**  
**DAY TREATMENT WEEKLY PROGRESS NOTE**  
**Instructions**

**UNAVOIDABLE ABSENCES:** When a client has missed a section of allotted time for Day Treatment, you must determine if the absence was Avoidable or Unavoidable. If a client misses time to an Avoidable Absence, the State has determined that the entire day is NOT billable.

- *Avoidable Absence:* the State has determined that the entire day is NOT billable when a client misses time due to an Avoidable Absence.
- *Unavoidable Absence:* When these absences occur, mark the box that corresponds with the date the client missed time. Then in the box provide a brief reason. A more thorough description of the absence can be given in the Significant Weekly Information section or if a pattern has emerged, it can be explained in that section.

**ABSENCE TIME:** When a client has either of the above mentioned absences, documentation of the Absence Time In & Out must be added. These times must also correlate with the Sign In/Out Sheets used to track program attendance.

**SIGNIFICANT WEEKLY INFORMATION:** This section should provide information to obtain a clear picture of services provided throughout the week in order to justify the time billed to Medi-cal. Breaking out and providing examples of the different services: Process groups, Skill building groups and Adjunctive therapies is required in this section along with indicating the impairment, response and progress. Using the Program Schedule may be helpful in determining provided services for the week.

**GOALS:** List the Goals from the Client Plan in these sections

**INTERVENTIONS AND PROGRESS TOWARDS CLIENT PLAN GOALS:** Indicate specific interventions offered to client during the week. Include client's progress towards meeting their goals for the week. This section should encompass observation throughout the week, not just one day/interaction.

**FAMILY THERAPY:** Documentation regarding the Family Therapy offered may be done in this space if a separate note is not completed. If a separate note is completed, can indicate "see Family Therapy note dated \_\_/\_\_/\_\_" and then file the note with the Weekly.

**SUMMARY OF OTHER INTERVENTIONS:** This section could provide information regarding Pathways to Well Being or other services that are not indicated in the Service Components above.

**SUMMARY OF TREATMENT TEAM REVIEW:** Include information regarding updates that occurred during a Treatment Team meeting. This could include medication changes, concerns, and placement considerations.

**HAS A PATTERN OF ABSENCES EMERGED?:** Mark the appropriate box and if yes, answer what actions have been taken to mitigate.

**SIGNATURES:** If a Co-Signature is required, it must be completed by a Licensed or Licensed Waivered Staff

**San Diego County Mental Health Services  
DAY TREATMENT WEEKLY PROGRESS NOTE  
Instructions**

<b>STAFF DISCIPLINE</b>	<b>Day Rehab Weekly Summary Co-Signature Required?</b>
Ph.D Psy.D licensed/waivered	NO
Ph.D Psy.D registered	YES
LCSW, MFT licensed/registered/waivered	NO
Licensed Professional Clinical Counselor (LPCC) Professional Counselor Intern (PCI)	NO
Mental Health Rehab Specialist (MHRS)	YES
Staff not meeting minimum qualifications for MHRS (Trainee, etc)	YES



Client:		Client #:		Program:	
Date of Service:		Unit:		SubUnit:	
Server ID:		Service Time:		Travel Time:	
Person Contacted:		Place:		Appointment Type:	
Outside Facility:		Contact Type:			
Diagnosis At Service (This client): ICD-10 Code(s):					
Overview of Group:(Describe the focus of the group and the intended outcome – a global description of the group, not individualized for each client. Justify need for Collateral Server)				Service:	
Collateral Server ID:		Service Time:		Documentation Time:	
Collateral Server ID:		Service Time:		Documentation Time:	
<b>GROUP PROGRESS NOTE</b>					
<b>CLIENT AFFECT/MOOD:</b>					
<b>CLIENT APPEARANCE:</b>					
<b>LEVEL OF ORIENTATION</b> (person, place, time, day, month, year, current situation):					
<b>PRECIPITATORS/RECENT STRESSORS:</b> :					
<b>SAFETY ISSUES:</b> (include client's complaints/symptoms/focus of group/interventions):					
<b>PARTICIPATION IN GROUP</b> (complaints/symptoms/interventions):					
<b>PROGRESS TOWARDS GOALS/OBJECTIVES:</b>					
<b>PLAN:</b>					
_____ Signature/Title/Credential				Date	
_____ Co-Signature/Title/Credential				Date	
				Printed Name/Credential/Server ID#	
				Printed Name/Credential/Server ID#	

County of San Diego  
Health and Human Services Agency  
Mental Health Services

**GROUP PROGRESS NOTE**  
HHS:MHS-684 (8-19-15)

**Client:**

**Case #:**

**Program:**









**SYMPTOMATIC RESPONSE TO MEDICATION:**     Full Remission     Partial     No Change     Worsening

If medication type or dose is being changed at this visit, indicate reasons for change.

\*\*  Critical Decision Points Indicates Change     Diagnosis Change     Insufficient Improvements     Client Preference  
 Side Effects Intolerable     Symptoms Worsening     Other (specify) \_\_\_\_\_

Comments:

**D. MENTAL STATUS EXAM:**

<b>Level of Consciousness:</b>	<input type="checkbox"/> Alert	<input type="checkbox"/> Lethargic	<input type="checkbox"/> Stuporous				
<b>Orientation:</b>	<input type="checkbox"/> Person	<input type="checkbox"/> Place	Time <input type="checkbox"/> Day <input type="checkbox"/> Month <input type="checkbox"/>	<input type="checkbox"/> Current Situation	<input type="checkbox"/> All Normal		
<b>Appearance:</b>	<input type="checkbox"/> Clean	<input type="checkbox"/> Disheveled	<input type="checkbox"/> Malodorous	<input type="checkbox"/> Well-Nourished	<input type="checkbox"/> Malnourished	<input type="checkbox"/> Obesity	<input type="checkbox"/> Reddened Eyes
<b>Speech:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Slurred	<input type="checkbox"/> Loud	<input type="checkbox"/> Pressured	<input type="checkbox"/> Slow	<input type="checkbox"/> Mute	
<b>Thought Process:</b>	<input type="checkbox"/> Coherent	<input type="checkbox"/> Tangential	<input type="checkbox"/> Circumstantial	<input type="checkbox"/> Incoherent		<input type="checkbox"/> Loose Association	
<b>Thought Content</b>	<input type="checkbox"/> Auditory Hallucinations	<input type="checkbox"/> Visual Hallucinations	<input type="checkbox"/> Delusions	<input type="checkbox"/> Ideas of Reference		<input type="checkbox"/> Paranoia	
<b>Behavior:</b>	<input type="checkbox"/> Cooperative	<input type="checkbox"/> Evasive	<input type="checkbox"/> Uncooperative	<input type="checkbox"/> Threatening	<input type="checkbox"/> Agitated	<input type="checkbox"/> Combative	
<b>Affect:</b>	<input type="checkbox"/> Appropriate	<input type="checkbox"/> Blunted	<input type="checkbox"/> Flat	<input type="checkbox"/> Restricted	<input type="checkbox"/> Labile	<input type="checkbox"/> Other	
<b>Intellect:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Below Normal	<input type="checkbox"/> Paucity of Knowledge	<input type="checkbox"/> Vocabulary Poor	<input type="checkbox"/> Poor Abstraction	<input type="checkbox"/> Uncooperative	
<b>Mood:</b>	<input type="checkbox"/> Euthymic	<input type="checkbox"/> Elevated	<input type="checkbox"/> Euphoric	<input type="checkbox"/> Depressed	<input type="checkbox"/> Anxious	<input type="checkbox"/> Irritable	
<b>Memory:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Poor Recent	<input type="checkbox"/> Poor Remote	<input type="checkbox"/> Inability to Concentrate	<input type="checkbox"/> Confabulation	<input type="checkbox"/> Amnesia	
<b>Insight</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Adequate	<input type="checkbox"/> Marginal	<input type="checkbox"/> Poor			
<b>Judgment:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Poor	<input type="checkbox"/> Unrealistic	<input type="checkbox"/> Unmotivated	<input type="checkbox"/> Uncertain		
<b>Motor:</b>	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Agitated	<input type="checkbox"/> Tremors	<input type="checkbox"/> Tics	<input type="checkbox"/> Repetitive Motions	<input type="checkbox"/> Psycho-Motor Retardation
<b>Global AIMS:</b>	0	1	2	3	4		

Note: A narrative mental status exam may be done on a progress note, in lieu of above.

**ICD-10 DIAGNOSIS:** . . . ; . . . ; . . . ; . . .

**E. Psychotherapeutic interventions: Return visit, discharge planning.**

**F. Plan/Order/SNP: Psychotherapeutic Interventions: Return visit, discharge planning. Medication Levels. Lab Work.**

Service:		Service Time:	Travel Time:	Documentation Time:
Person Contacted:	Place:	Outside Facility:	Contact Type:	Appointment Type:

\_\_\_\_\_  
 Signature /Title                                      Printed Name/Title/Credential                      Server ID#                                      Date

Comments:

\_\_\_\_\_  
 Signature /Title                                      Printed Name/Title/Credential                                      Date

County of San Diego  
 Health and Human Services Agency  
 Mental Health Services

**MEDICATIONS PROGRESS NOTE**  
 HHSA:MHS-125 (8-19-15)

**Client:**

**Case #:**

**Program:**  
**Address:**

**Phone:**

# PROGRESS NOTES

## COMPLETED BY:

1. Staff delivering services within scope of practice. Co-signatures must be completed within timelines.

## COMPLIANCE REQUIREMENTS:

1. A Progress Note must be completed after every service contact with the client.
2. Content of each progress note must support the service claimed.
3. When using a template all prompts must be addressed.
4. Data must be entered into the Electronic Health Record.
5. Every progress note within the EHR must be completed and final approved within 14 calendar days (service date is Day 1).
  - a. **Notes not completed within 14 calendar days (Service Date is Day 1) must be billed with nonbillable service codes, and are subject to recoupment if claimed.**

## DOCUMENTATION STANDARDS:

1. QM has established a **five business day** standard for completion of documentation and final approval of progress notes.
2. Service entry shall be completed as a part of the progress noting process.
3. Completion and final approval of the service and the progress note by the staff is a certification that the documented services were provided personally and that the services were medically necessary.
4. When it is not completed and final approved, the note is at risk for deletion by another server.
5. Paper forms are only to be completed when the EHR is not accessible and/or when staff have not yet been trained in the EHR. In these cases the services will be entered manually into the EHR.
  - a. Note: Paper progress notes will be completed by Day Rehab staff, and Medical staff who do not enter into the EHR.
6. Progress notes are not viewed as complete until they are final approved.

# DAY TREATMENT WEEKLY SUMMARY

## COMPLETED BY:

1. Licensed/Waivered Psychologist
2. Licensed/Waivered/Registered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Registered Nurse\*
6. Registered Psy D and Trainee\*
7. Mental Health Rehab Specialist (MHRS)\*

## COMPLIANCE REQUIREMENTS:

1. When addressing Service Delivery, only mark the corresponding box in which the client attended the service.
2. Dates, including years, are required for Monday-Friday boxes and must match with the services being provided.
3. Total attendance time should equal the corresponding sign in/out sheets and should be reflected in the billed time to Medi-cal.
4. When a client misses a section of allotted time for Day Treatment and the time missed was due to an Avoidable Absence, the entire day becomes NOT billable.
5. When a client misses a section of allotted time for Day Treatment and the time missed was due to an Unavoidable Absence and a description of the reason missed must be included.
6. Any absence to the Day Treatment program must document Time In and Time Out.
7. Significant weekly information must include specific services, such as: process groups, skill building groups, and adjunctive therapies; as well as indicating client's impairment and response.
8. Client's goals, progress towards goals, and interventions must be addressed.
9. A Weekly Summary is not valid until all signatures are obtained within 14 days from the initial date of service indicated on the Weekly.
  - a. \*RN's, Registered Psy D, Trainee, and MHRS cannot diagnose a mental illness due to scope of practice and therefore require co-signatures if completing Weekly Summary Documentation.

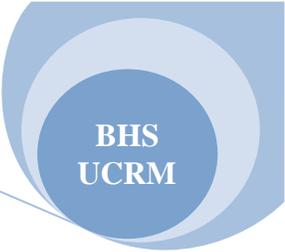
## DOCUMENTATION STANDARDS:

1. Individual, group and family therapy may be documented on separate notes or included within the individual sections within the Weekly itself.
2. Weekly Summaries are completed on paper and placed within the hybrid chart.
3. Collateral information should be documented on a regular basis, at minimum monthly.

# MEDICAL

## Section 6

# Abnormal Involuntary Movement Scale (AIMS)

The logo for BHS UCRM is located in the top right corner. It consists of three concentric circles in shades of blue, with the text "BHS" above "UCRM" in white, centered within the innermost circle.

BHS  
UCRM

## **COMPLETED BY:**

1. Physician (MD or DO)
2. RN

## **COMPLIANCE REQUIREMENTS:**

1. Completed for all clients receiving anti-psychotropic medication.
2. The following areas must be addressed:
  - a. Facial and oral movements
  - b. Extremity movements
  - c. Trunk movements
  - d. Global judgements
  - e. Dental status
  - f. Response to medication
3. If all the above areas are documented within the progress note, then the AIMS does not need to be completed.

## **DOCUMENTATION STANDARDS:**

1. For clients under sixty (60) years of age due once a year and for clients over sixty (60) years of age every six (6) months.
2. All data must be entered into the EHR.

**San Diego County Mental Health Services**  
**ABNORMAL INVOLUNTARY MOVEMENT SCALE**  
**(AIMS)**

**\*Client Name:**

**\*Case #:**

**\*Date:**

**\*Program Name:**

**FACIAL AND ORAL MOVEMENTS**

- |                                 |                               |                                  |                               |                                   |                                 |
|---------------------------------|-------------------------------|----------------------------------|-------------------------------|-----------------------------------|---------------------------------|
| 1. Muscles of Facial Expression | <input type="checkbox"/> None | <input type="checkbox"/> Minimal | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| 2. Lips and Perioral Area       | <input type="checkbox"/> None | <input type="checkbox"/> Minimal | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| 3. Jaw                          | <input type="checkbox"/> None | <input type="checkbox"/> Minimal | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| 4. Tongue                       | <input type="checkbox"/> None | <input type="checkbox"/> Minimal | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |

**EXTREMITY MOVEMENTS**

- |   |                               |                                  |                               |                                   |                                 |
|---|-------------------------------|----------------------------------|-------------------------------|-----------------------------------|---------------------------------|
| 5. Upper (Arms, Wrist, Hands,<br>Fingers) | <input type="checkbox"/> None | <input type="checkbox"/> Minimal | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| 6. Lower (Legs, Knees, Ankles, Toes)      | <input type="checkbox"/> None | <input type="checkbox"/> Minimal | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |

**TRUNK MOVEMENTS**

- |                          |                               |                                  |                               |                                   |                                 |
|--------------------------|-------------------------------|----------------------------------|-------------------------------|-----------------------------------|---------------------------------|
| 7. Neck, Shoulders, Hips | <input type="checkbox"/> None | <input type="checkbox"/> Minimal | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
|--------------------------|-------------------------------|----------------------------------|-------------------------------|-----------------------------------|---------------------------------|

**GLOBAL JUDGMENTS**

- |   |   |                                  |                               |                                   |                                 |
|---|---|----------------------------------|-------------------------------|-----------------------------------|---------------------------------|
| 8. Severity of Abnormal<br>Movements          | <input type="checkbox"/> None   | <input type="checkbox"/> Minimal | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| 9. Incapacity Due to Abnormal<br>Movements    | <input type="checkbox"/> None   | <input type="checkbox"/> Minimal | <input type="checkbox"/> Mild | <input type="checkbox"/> Moderate | <input type="checkbox"/> Severe |
| 10. Patient's Awareness of Abnormal Movements | <input type="checkbox"/> No awareness<br><input type="checkbox"/> Aware, no distress<br><input type="checkbox"/> Aware, mild distress<br><input type="checkbox"/> Aware, moderate distress<br><input type="checkbox"/> Aware, severe distress |                                  |                               |                                   |                                 |

**DENTAL STATUS**

- |                                      |                              |                             |
|--------------------------------------|------------------------------|-----------------------------|
| Current Problems with Teeth/Dentures | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Does Client Usually Wear Dentures    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

TOTAL Tardive Dyskinesia-Like Score

Any Other Important Information, Comments or Concerns:

**\*Signature of Physician or Nurse Completing Examination:**

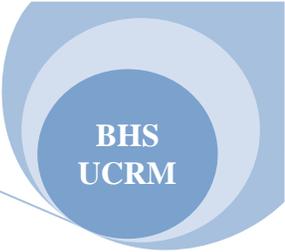
\_\_\_\_\_  
Signature

Date

Printed Name

Anasazi ID #:

# **COORDINATION WITH PRIMARY CARE PHYSICIANS BEHAVIORAL HEALTH SERVICES**

The logo for Behavioral Health Services (BHS) at the University of Central Florida (UCRM). It consists of three overlapping circles in shades of blue, with the text "BHS" above "UCRM" in white, centered within the circles.

**BHS  
UCRM**

## **COMPLETED BY:**

1. Any direct service staff providing treatment to client.

## **COMPLIANCE REQUIREMENTS:**

1. Complete within 30 days of assignment open.
2. Update with significant changes.
3. Shall be completed on all clients, regardless if they have a Primary Care Physician or not.
4. Form must be signed by client.

## **DOCUMENTATION STANDARDS:**

1. All required areas shall be completed.
2. Please refer to the Instruction sheet that is included with the form for further detail.

## Coordination with Primary Care Physicians and Behavioral Health Services

Coordination of care between behavioral health care providers and health care providers is necessary to optimize the overall health of a client. Behavioral Health Services (BHS) values and expects coordination of care with health care providers, linkage of clients to medical homes, acquisition of primary care provider (PCP) information and the entry of all information into the client's behavioral health record. With healthcare reform, BHS providers shall further strengthen integration efforts by improving care coordination with primary care providers. Requesting client/guardian authorization to exchange information with primary care providers is mandatory, and upon authorization, communicating with primary care providers is required. **County providers shall utilize the *Coordination and/or Referral of Physical & Behavioral Health Form & Update Form*, while contracted providers may obtain legal counsel to determine the format to exchange the required information. This requirement is effective immediately and County QI staff and/or COTR will audit to this standard beginning FY 13-14.**

### For all clients:

#### Coordination and/or Referral of Physical & Behavioral Health Form:

- Obtain written consent from the client/guardian on the *Coordination and/or Referral of Physical & Behavioral Health Form*/contractor identified form at intake, but no later than 30 days of episode opening.
- For clients that do not have a PCP, provider shall connect them to a medical home. Contractor will initiate the process by completing the *Coordination and/or Referral of Physical & Behavioral Health Form*/contractor form and sending it to the PCP within 30 days of episode opening. It is critical to have the specific name of the treating physician.
- Users of the form shall check the appropriate box at the top of the *Coordination and/or Referral of Physical & Behavioral Health Form*/contractor form noting if this is a referral for physical healthcare, a referral for physical healthcare and medication management, a referral for total healthcare, or coordination of care notification only. If it is a referral for physical healthcare, or physical healthcare and medication management, type in your program name in the blank, and select appropriate program type.

#### Coordination of Physical and Behavioral Health Update Form:

- Update and send the *Coordination of Physical and Behavioral Health Update Form*/contractor form if there are significant changes like an addition, change or discontinuation of a medication.
- Notify the PCP when the client is discharged from services by sending the *Coordination of Physical and Behavioral Health Update Form*/contractor form. The form shall be completed prior to completion of a discharge summary.

#### Tracking Reminders:

- Users of the form shall have a system in place to track the expiration date of the authorization to release/exchange information.
- Users of the form shall have a system in place to track and adhere to any written revocation for authorization to release/exchange information.
- Users of the form shall have a system in place to track and discontinue release/exchange of information upon termination of treatment relationship. Upon termination of treatment the provider may only communicate the conclusion of treatment, but not the reason for termination.



**Coordination and/or Referral of Physical & Behavioral Health Form**

- Referral for *physical* healthcare – [ \_\_\_\_\_ ] will continue to provide specialty behavioral health services  
 Mental Health       Alcohol and Drug
- Referral for *physical* healthcare & Medication Management – [ \_\_\_\_\_ ] will continue to provide limited specialty behavioral health services  
 Mental Health       Alcohol and Drug
- Referral for *total* healthcare – [ \_\_\_\_\_ ] is no longer providing specialty behavioral health services.  
 Available for psychiatric consult.
- Coordination of care notification only.

**Section A: CLIENT INFORMATION**

Client Name: Last	First	Middle Initial	AKA	<input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address			Date of Birth	
City			Telephone #	
Zip			Alternate Telephone #	

**Section B: BEHAVIORAL HEALTH PROVIDER INFORMATION**

Name of Treatment Provider:	Name of Treating Psychiatrist (If applicable)
Agency/Program	
Street Address	City, State, Zip
Telephone #	Specific provider secure fax # or secure email address:
Date of Initial Assessment:	
Focus of Treatment ( <i>Use Additional Progress Note if Needed</i> )	
Case Manager/ Mental Health Clinician/ Alcohol and Drug Counselor/ Program Manager:	Behavioral Health Nurse: Phone #:



Date Last Seen	Mental Health Diagnoses:
	Alcohol and Drug Related Diagnoses:

Current Mental and Physical Health Symptoms *(Use Additional Progress Note if Needed)*

Current Mental Health and Non-Psychiatric Medication and Doses  
*(Use Additional Medication/Progress Note if Needed)*

Last Psychiatric Hospitalization  
 Date:  None

**Section C: PRIMARY CARE PHYSICIAN INFORMATION**

Provider's Name

Organization OR Medical Group

Street Address

City, State, Zip

Telephone #:	Specific provider secure fax # or secure email address:
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**Section D: FOR PRIMARY CARE PHYSICIAN COMPLETION  
 ACCEPTED FOR TREATMENT OR REFERED BACK TO SDCBHS  
 PROGRAM (PLEASE COMPLETE THE FOLLOWING INFORMATION AND  
 RETURN TO BEHAVIORAL HEALTH PROVIDER WITHIN TWO WEEKS  
 OF RECEIPT)**

Coordination of Care notification received.  
 If this is a primary care referral, please indicate appropriate response below:

1.  Patient accepted for physical health treatment only
2.  Patient accepted for physical healthcare and psychotropic medication treatment while additional services continue with behavioral health program
3.  Patient accepted for total healthcare including psychotropic medication treatment
4.  Patient not accepted for psychotropic medication treatment and referred back due to:



**Sensitive Information:** I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about mental health services or treatment for alcohol and drug abuse.

**Right to Revoke:** I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

**Photocopy or Fax:**

I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

**Redisclosure:** If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

**Other Rights:** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section 164.524.

**SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE**

SIGNATURE:	DATE:
------------	-------

**Client Name (Please type or print clearly)**

<b>Last:</b>	<b>First:</b>	<b>Middle:</b>
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IF SIGNED BY LEGAL REPRESENTATIVE, PRINT NAME:	RELATIONSHIP OF INDIVIDUAL:
--	-----------------------------

**Expiration:** Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_

**If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed, or 60 days after termination of treatment.**

- |  |  |
|--|--|
| <input type="checkbox"/> Information Contained on this form<br><input type="checkbox"/> Current Medication & Treatment Plan<br><input type="checkbox"/> Substance Dependence Assessments<br><input type="checkbox"/> Assessment /Evaluation Report | <input type="checkbox"/> Discharge Reports/Summaries<br><input type="checkbox"/> Laboratory/Diagnostics Test Results<br><input type="checkbox"/> Medical History<br><input type="checkbox"/> Other _____ |
|--|--|

*The above signed authorizes the behavioral health practitioner and the physical health practitioner to release the medical records and Information/updates concerning the patient. The purpose of such a release is to allow for coordination of care, which enhances quality and reduces the risk of duplication of tests and medication interactions. Refusal to provide consent could impair effective coordination of care.*



I would like a copy of this authorization  Yes  No  
Clients/Guardians Initials

**→ Please place a copy of this Form in your client's chart**

**TO REACH A PLAN REPRESENTATIVE**

Care1st Health Plan  
(800) 605-2556

Community Health Group  
(800) 404-3332

Health Net  
(800) 675-6110

Kaiser Permanente  
(800) 464-4000

Molina Healthcare  
(888) 665-4621

Access & Crisis Line  
(888) 724-7240





COORDINATION OF PHYSICAL AND BEHAVIORAL HEALTH UPDATE FORM

**CLIENT NAME**

Last	First	Middle
Date of Birth	<input type="checkbox"/> Male	<input type="checkbox"/> Female

**BEHAVIORAL HEALTH UPDATE**

Treating Provider Name	Phone	FAX
------------------------	-------	-----

Treating Psychiatrist Name (If applicable)	Phone	FAX
--	-------	-----

<input type="checkbox"/> Medications prescribed on _____ Date	Name/Dosage: _____
<input type="checkbox"/> Medications changed on _____ Date	Name/Dosage: _____
<input type="checkbox"/> Medications discontinued on _____ Date	Name/Dosage: _____

<input type="checkbox"/> Medications prescribed on _____ Date	Name/Dosage: _____
<input type="checkbox"/> Medications changed on _____ Date	Name/Dosage: _____
<input type="checkbox"/> Medications discontinued on _____ Date	Name/Dosage: _____

**Diagnosis Update :**

**Key Information Update:**

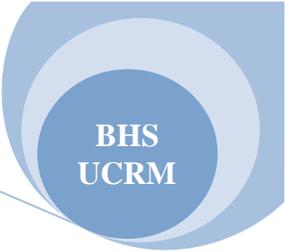
**Discharge from Treatment Date:**

**Follow-up Recommendations:**

**PRIMARY CARE PHYSICIAN UPDATE**

Please provide any relevant Update/Change to Patient's Physical Health Status.

# Medical Condition Review Form

The logo for BHS UCRM is located in the top right corner. It consists of three concentric blue circles of varying shades, with the text "BHS" above "UCRM" centered within the innermost circle.

BHS  
UCRM

## **COMPLETED BY:**

1. Physician (MD or DO)
2. RN if supporting the medical staff.

## **COMPLIANCE REQUIREMENTS:**

1. Form shall be completed in Doctor's Homepage in the EHR.
2. All clinically appropriate elements shall be completed.
3. Shall be completed by all clients seen by a medical staff.

## **DOCUMENTATION STANDARDS:**

1. In the event of a system outage, this form is used for documenting a client's vitals, allergies and medical condition. Enter the Medical Condition Review into the DHP as soon as the system becomes available again.

## Medical Condition Review

Client Name: \_\_\_\_\_

Client Number: \_\_\_\_\_

### General Information

Height: \_\_\_\_\_ ft \_\_\_\_\_ in BMI: \_\_\_\_\_

Weight: \_\_\_\_\_ lbs \_\_\_\_\_ oz Waist Circumference: \_\_\_\_\_

Pregnant  Lactating/Nursing  Fathering a child

### Vital Signs

Blood pressure: \_\_\_\_\_ mmHg systolic \_\_\_\_\_ mmHg diastolic

Temperature: \_\_\_\_\_ F Heart Rate: \_\_\_\_\_/min Respiratory Rate: \_\_\_\_\_/min

Blood Glucose Level: \_\_\_\_\_ mg/dL

### Liver/Renal Conditions

Liver Disease

Renal Function: \_\_\_\_\_ mL/min Dialysis Type: \_\_\_\_\_

Medical Conditions  No Known Medical Conditions

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Allergies  No Known Medication Allergies  No Known Substance Allergies

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Staff Signature: \_\_\_\_\_ Staff ID: \_\_\_\_\_

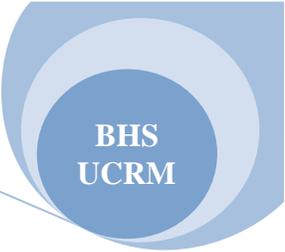
DATE: \_\_\_\_\_

## Instructions for System Outage

**WHEN:**

Once you have been trained to use the Doctor's Homepage in Anasazi, the expectation is that all medications be entered into Anasazi via the Doctor's Homepage. In the event of a system outage write prescriptions as you would on paper and follow what has been procedure prior to access to DHP. Enter the information into the DHP for the client as the system becomes available. You will not transmit electronically – make sure to mark the prescription method appropriately (handwritten, called in or faxed).

# PSYCHIATRIC ASSESSMENT

The logo for BHS UCRM is located in the top right corner. It consists of three concentric circles in shades of blue, with the text "BHS" above "UCRM" in white, centered within the innermost circle.

BHS  
UCRM

## COMPLETED BY:

1. Physician (MD or DO)
2. MD Trainee
3. Nurse Practitioner
4. Nurse Practitioner Trainee (with a co-signature)\*

## COMPLIANCE REQUIREMENTS:

1. Completed for every client at the time client is initially evaluated for medication.
2. Updated as clinically indicated throughout the course of treatment.
3. All clinically appropriate elements shall be completed.

## DOCUMENTATION STANDARDS:

1. Data shall be entered into the EHR.
2. Psychiatric Assessments are not complete until signed and final approved in the EHR.
  - a. \*A co-signature is required for Nurse Practitioner Trainees
3. A Psychiatric Assessment that is not final approved could risk deletion from another program.
4. For more detailed information please refer to the Psychiatric Assessment Instruction Sheet located on the Optum website.

**San Diego County Mental Health Services  
PSYCHIATRIC ASSESSMENT**

\*Client Name: \_\_\_\_\_ \*Case Number: \_\_\_\_\_  
 \*Assessment Date: \_\_\_\_\_ \*Program Name: \_\_\_\_\_

**\*PRESENTING PROBLEMS/NEEDS** *Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and history of present illness. Summary of client's request for services including client's most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors; include experiences of stigma and prejudice, if any.*

**CLINICAL UPDATE** *Interval note, describe current presentation and risk assessment to include danger to self and others, reason for visit.*

**\*PAST PSYCHIATRIC HISTORY** *Previous history of symptoms and/or mental health treatment. Describe in chronological order - where, when, and length of time. Include dates and providers related to any prior psychiatric treatment, history, traumatic and/or significant events, and/or trauma related to treatment. Include the most recent periods of stability and the characteristics of those periods.*

**SUBSTANCE USE INFORMATION:**

\*History of Substance Use?       No       Yes       Client Declined to Report?

(if yes, specify substances used)

Name of Drug	Priority	Method of Administration	Age 1 <sup>st</sup> used	Freq- uency of Use	Days of use in last 30 days	Date of last use	Amount of last use	Amount used on a typical Day	Largest Amount Used in One Day

The client has been advised that smoking is a serious health risk that may lead to lung cancer, cardiovascular disease and the possibility of premature death.  
 Yes       N/A

When applicable, outline how substance use impacts current level of functioning:

History of substance use treatment:

Client Name:**Error! Reference source not found.**

Case Number:

Program Name:

Assessment Date:

Recommendation for further substance use treatment:  No  Yes  Not applicable  
If Yes:

**FAMILY HISTORY:**

\*Living Arrangement: *Select from Living Arrangement table listed in the Instructions Sheet*

Those living in the home with client:

Have any relatives ever had any of the following conditions *Select from Relatives table listed in the Instructions Sheet*.

Substance abuse or addiction:

Other addictions:

Suicidal thoughts, attempts:

Emotional/mental health issues:

Mental retardation:

Developmental delays:

Arrests:

Include relevant family information impacting the client:

**MEDICAL HISTORY**

\*Does client have a Primary Care Physician?  No  Yes  Unknown

If No, has client been advised to seek primary care?  No  Yes

Primary Care Physician:

Phone Number:

Seen within the last:  6 months  12 months  Other:

Hospital of choice (physical health):

Been seen for the following (provide dates of last exam):

Dental exam:

Hearing exam

Vision exam:

Physical Health issues:

Asthma

Diabetes

Elevated BMI

Heart Disease

Hypertension

Kidney Disease

Liver Disease

Neurological

None at This Time

Sedentary Lifestyle

Seizure Disorder

Smoking

Other, specify:

Referred to primary health physician:  Yes  N/A

Physical health problems affecting mental health functioning:

Head injuries:  No  Yes, specify:

Medical and/or adaptive devices:

Client Name:**Error! Reference source not found.**

Case Number:

Program Name:

Assessment Date:

Significant Developmental Information (when applicable):

\*Allergies and adverse medication reactions: No Unknown/Not Reported  
 Yes, specify:

Other prescription medications:  None  Yes:

Herbals/Dietary Supplements/Over the counter medications:  None  Yes:

Healing and Health: *(Alternative healing practices and beliefs. Apart from mental health professionals, who or what helps client deal with disability/illness and/or to address substance use issues? Describe):*

Any known medical condition or past history of abuse that requires special consideration if physical restraint is needed, specifically: breathing problems, significantly overweight, pregnancy, etc? No Yes

If yes, explain:

**MMSE:**

**MENTAL STATUS EXAM**

Unable to assess at this time.

Level of Consciousness

Alert  Lethargic  Stuporous

Orientation

Person  Place  Day  Month  Year  Current Situation  
 All Normal  None

Appearance

Good Hygiene  Poor Hygiene  Malodorous  Disheveled  
 Reddened Eyes  Normal Weight  Overweight  Underweight

Speech

Normal  Slurred  Loud  Soft  Pressured  
 Slow  Mute

Thought Process

Coherent  Tangential  Circumstantial  Incoherent  Loose Association

Behavior

Cooperative  Evasive  Uncooperative  Threatening  Agitated  Combative

Affect

Appropriate  Restricted  Blunted  Flat  Labile  Other

Intellect

Average  Below Average  Above Average  Poor Vocabulary  
 Poor Abstraction  Paucity of Knowledge  Unable to Rate

Mood

Euthymic  Elevated  Euphoric  Irritable  Depressed  Anxious

Memory

Client Name:**Error! Reference source not found.**

Case Number:

Program Name:

Assessment Date:

- Normal       Poor Recent       Poor Remote       Inability to Concentrate
- Confabulation       Amnesia

Motor

- Age Appropriate/Normal       Slowed/Decreased       Psychomotor Retardation
- Hyperactive       Agitated       Tremors       Tics       Repetitive Motions

Judgment

- Age Appropriate/Normal       Poor       Unrealistic
- Fair       Limited       Unable to Rate

Insight

- Age Appropriate/Normal       Poor       Fair       Limited       Adequate       Marginal

Command Hallucinations

- No       Yes, specify:

Auditory Hallucinations

- No       Yes, specify:

Visual Hallucinations

- No       Yes, specify:

Tactile Hallucinations

- No       Yes, specify:

Olfactory Hallucinations

- No       Yes, specify:

Delusions

- No       Yes, specify:

Other observations/comments when applicable :

**DIAGNOSIS**

**If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Psychiatric Assessment.**

**VITAL SIGNS:**

Height	Weight	Temp	Resp	Pulse	BP

Pain:    No      Yes      Unable to determine

Pain Intensity Level:

Location of pain:

How long:



Client Name:**Error! Reference source not found.**

Case Number:

Program Name:

Assessment Date:

**\*Signature of Physician Completing/Accepting the Evaluation:**

\_\_\_\_\_  
Signature

Date:

Time:

Printed Name:

Anasazi ID number:

**Signature of Staff Entering Information (if different from above):**

\_\_\_\_\_  
Signature

Date:

Time:

Printed Name:

Anasazi ID number:

**San Diego County Mental Health Services  
PSYCHIATRIC ASSESSMENT  
Instructions**

**Anasazi Tab 1**

Program Name: Required Field.

Unit Number: Required Field.

**PRESENTING PROBLEMS/NEEDS:** This is a required field. Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and summary of client's request for services including client's most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors. Include information on 5150 and Police transport.

**CLINICAL UPDATE:** Document in the space provided. Interval note, describe current presentation and risk assessment to include danger to self and others, reason for visit.

**PAST PSYCHIATRIC HISTORY:** This is a required field. Previous history of symptoms and/or mental health treatment. Describe in chronological order - where, when, and length of time. Include dates and providers related to any prior psychiatric treatment, history, traumatic and/or significant events, and/or trauma related to treatment. Include the most recent periods of stability and the characteristics of those periods.

**SUBSTANCE USE INFORMATION:** Required field. Select "No" or "Yes" as it applies to the client. If client indicates "yes," provide information on which substances the client reports in the space provided.

If client declines to report substance use, indicate by checking the appropriate box.

Educate the client regarding the effects of smoking by reading the following statement: "Smoking is a serious health risk that may lead to lung cancer, cardiovascular disease and the possibility of premature death." Indicate that you have provided this advisement by selecting the "Yes" check box.

Use the space provided to document how substance use impacts the client's current level of functioning.

History of Substance Use Treatment: Provide types of treatment, level of care, length of treatment, etc.

Recommendation for Further Substance Use Treatment: Check box "No", "Yes", or "Not Applicable. If "yes," explain in the box provided.

**FAMILY HISTORY:**

The "Living Arrangement" prompt is Required.

Enter your response on the form based on the Living Arrangement Table below. Include the ID and Description in your documentation.

**Living Arrangement**

A-House or Apartment	G-Substance Abuse Residential Rehab Ctr	O-Other
B-House or Apt with Support	H-Homeless/In Shelter	R-Foster Home-Child
C-House or Apt with Daily Supervision Independent Living Facility	I-MH Rehab Ctr (Adult Locked)	S-Group Home-Child (Level 1-12)
D-Other Supported Housing Program	J-SNF/ICF/IMD	T-Residential Tx Ctr-Child (Level 13-14)
E-Board & Care – Adult	K-Inpatient Psych Hospital	U-Unknown
F-Residential Tx/Crisis Ctr – Adult	L-State Hospital	V-Comm Tx Facility (Child Locked)
	M-Correctional Facility	W- Children's Shelter

Those Living In The Home With The Client: List the names and relationship to client in the text box.

Include relevant family information impacting the client in the text box provided.

Have Any Relatives Ever Had Any Of The Following Conditions: For each listed condition, enter information from the family members table, if applicable, in the spaces provided. Leave blank if there are none:

ID	DESCRIPTION	ID	DESCRIPTION	ID	DESCRIPTION
<b>Aunt Bio</b>	Aunt – Biological	<b>Fath InLaw</b>	Father – In-Law	<b>Niece NBio</b>	Niece – Non-biological
<b>Aunt NoBio</b>	Aunt – Non-biological	<b>Gdaug Bio</b>	Granddaughter – Biological	<b>Other</b>	Other
<b>Bro Adop</b>	Brother – Adopted	<b>GDaug NBio</b>	Granddaughter – Non-biological	<b>Signif Oth</b>	Significant Other
<b>Bro Bio</b>	Brother – Biological	<b>GrFa Bio</b>	Grandfather – Biological	<b>Sig Supp</b>	Significant Support Person
<b>Bro Foster</b>	Brother – Foster	<b>GrFa NBio</b>	Grandfather – Non-biological	<b>Sis Adopt</b>	Sister – Adopted
<b>Bro InLaw</b>	Brother – In-Law	<b>GrMo Bio</b>	Grandmother – Biological	<b>Sis Bio</b>	Sister – Biological
<b>Bro Step</b>	Brother – Step	<b>GrMo NBio</b>	Grandmother – Non-biological	<b>Sis Foster</b>	Sister – Foster
<b>Cous Bio</b>	Cousin – Biological	<b>GrSon Bio</b>	Grandson – Biological	<b>Sis In Law</b>	Sister – In-Law
<b>Cous NBio</b>	Cousin – Non-biological	<b>GrSon NBio</b>	Grandson – Non-biological	<b>Sis Step</b>	Sister – Step
<b>Daug Adopt</b>	Daughter – Adopted	<b>Husband</b>	Husband	<b>Son Adopt</b>	Son – Adopted
<b>Daug Bio</b>	Daughter – Biological	<b>Mother Ado</b>	Mother – Adopted	<b>Son Bio</b>	Son – Biological
<b>Daug Foster</b>	Daughter – Foster	<b>Mother Bio</b>	Mother – Biological	<b>Son Foster</b>	Son – Foster
<b>Daug InLaw</b>	Daughter – In-Law	<b>Mother Fos</b>	Mother – Foster	<b>Son In Law</b>	Son – In-Law
<b>Daug Step</b>	Daughter – Step	<b>Mo In Law</b>	Mother – In-Law	<b>Son Step</b>	Son – Step
<b>Dom Partner</b>	Domestic Partner	<b>Mo Step</b>	Mother – Step	<b>Uncle Bio</b>	Uncle - Biological
<b>Fath Adop</b>	Father – Adopted	<b>Neph Bio</b>	Nephew – Biological	<b>Uncl NBio</b>	Uncle – Non-biological
<b>Fath Bio</b>	Father – Biological	<b>Neph NBio</b>	Nephew – Non-biological	<b>Wife</b>	Wife
<b>Fath Fost</b>	Father – Foster	<b>Niece Bio</b>	Niece – Biological		

Include relevant family information impacting the client: (Further explain family member’s involvement in substance use)

**MEDICAL HISTORY:**

Does client have a Primary Care Physician: This is a required field. Check box “No”, “Yes”, “Unknown” If No, check “No” or “Yes” client been advised to seek primary care.

Primary Care Physician: Enter the name and phone number of the physician in the text boxes provided. “Seen within the Last” period of time question is a required field. Check box “6 months”, “12 months”, or “Other” and explanation in text box provided.

The “Physical Health Issues” prompt is a Required Field. Check boxes for health issues are provided. Check all that apply.

The Allergies and adverse medication reactions” prompt is a Required Field.

Referred to primary health physician: Check box “Yes” or “N/A”.

Physical health problems affecting mental health functioning: Explain in text box provided.

Head Injuries: Check box “No” or “Yes”. If Yes, specify.

Describe any medical and/or adaptive devices used by client.

Describe any significant developmental information (when applicable).

Allergies and adverse medication reactions is a required field. Check box “No”, or “Yes”. If yes, specify in text box provided

Other prescription medications: Check box “None” or “Yes”. If Yes, describe in text box provided.

Herbals/Dietary Supplements/Over the counter medications: Check box “None” or “Yes”. If Yes, describe in text box provided.

Healing and Health: Alternative healing practices and beliefs. Apart from mental health professionals, who or what helps client deal with disability/illness and/or to address substance use issues?

Any known medical condition or past history of abuse that requires special consideration if physical restraint is needed, specifically: breathing problems, significantly overweight, pregnancy, etc? Check box “No”, “Yes”. If yes, explain.

**MMSE: (Mini Mental Status Exam):** Enter 2 digit code

*Anasazi Tab 2*

**MENTAL STATUS EXAM :** This is a Required Field. Check each area as applicable to client. Document other observations in the space provided.

*Anasazi Tab 3*

**DIAGNOSIS**

**If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Psychiatric Assessment.**

*Anasazi Tab 4*

**VITAL SIGNS:** Enter appropriate values for each prompt.

Pain: Check box “No”, “Yes”, “Unable to determine”.

Pain intensity level: Enter information in text box provided.

Location of pain: Enter information in text box provided, and how long client has had pain.

Doctor notified: Enter information in text box provided.

**DIAGNOSTIC SUMMARY:** Document the summary of your assessment in the space provided.

**PLAN:** Enter documentation of the Psychosocial/Rehab needs in the space provided. Include available treatment and/or recovery services recommended, within your program or in the community.

**PRESCRIPTIONS ORDERED NOW: (NOTE: This area only needs to be completed by programs that are given exceptions to the DHP. All other programs need to complete information in DHP as instructed.)**

If client is taking psychiatric or psychotropic medications enter in medication table provided in the form.

For “Side Effects Discussed”, “Medication Consent Forms”, “Ex-Parte” and “Conservator”, check boxes “No”, “Yes”, or “N/A”.

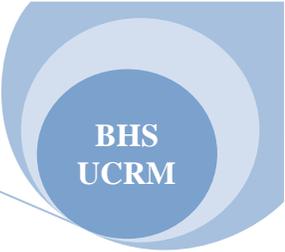
Diagnostic Examinations Ordered Now: Enter information in space provided.

Laboratory Tests Ordered Now: Enter information in space provided

Placement Needs: Enter information in space provided

**SIGNATURES:** Enter the name, credential, date and Anasazi ID number for the Physician requiring a co-signature (if applicable); and/or the Physician completing/accepting the evaluation.

# VITAL SIGNS /WEIGHT/HEIGHT RECORD

The logo for BHS UCRM is located in the top right corner. It consists of three overlapping circles in shades of blue, with the text "BHS" above "UCRM" in white, centered within the innermost circle.

BHS  
UCRM

## **COMPLETED BY:**

1. Physician (MD or DO)
2. Registered Nurse
3. LVN

## **COMPLIANCE REQUIREMENTS:**

1. Data shall be entered into the EHR.
2. Shall be completed for any client that has visits with medical staff.
3. All clinically appropriate elements shall be completed.

## **DOCUMENTATION STANDARD:**

1. Assessment and tracking of physiological parameters is encouraged at every physician visit.
2. The Vital Signs Record is not complete until it is final approved in the EHR.

**San Diego County Mental Health Services**

**VITAL SIGNS/WEIGHT/HEIGHT RECORD**

**\*Client Name:**

**\*Case #:**

**\*Program Name:**

**\*Date:**

**\*Time:**

<b>Temperature:</b>	
<b>Pulse:</b>	
<b>Respiration:</b>	
<b>Weight</b>	
<b>Height</b>	
<b>Blood Pressure</b>	

**Reason Taken:**

**Signature of MD, RN or LVN:**

\_\_\_\_\_

Date

Time

Printed Name:

Staff ID Number:

**Signature of Staff:**

\_\_\_\_\_

Date

Time

Printed Name:

Staff ID Number:

# ADMINISTRATIVE LEGAL Section 7



ACKNOWLEDGEMENT OF  
NOTICE OF PRIVACY PRACTICES

CLIENT'S INFORMATION		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
IF YOU ARE NOT THE CLIENT, PRINT YOUR NAME:		INDICATE YOUR RELATIONSHIP TO CLIENT:

Our Notice of Privacy Practices provides information about how we may use and share your medical information. We encourage you to read it fully.

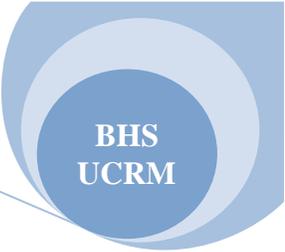
Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by accessing the County's web site, [www.cosdcompliance.org](http://www.cosdcompliance.org), or by contacting any staff person involved with your care.

If you have any questions about our Notice of Privacy Practices, please contact:

HHS Agency Privacy Officer  
County of San Diego  
Agency Compliance Office  
P.O. Box 865524 (Mail Stop: P501)  
San Diego, CA 92186-5524  
(619) 338-2808

I acknowledge receipt of the Notice of Privacy Practices of the County of San Diego	
SIGNATURE:	DATE:

# ADVANCE DIRECTIVE ADVISEMENT

The logo for BHS UCRM is located in the top right corner. It consists of three concentric blue circles of varying shades, with the text "BHS" above "UCRM" in white, centered within the innermost circle.

BHS  
UCRM

## COMPLETED BY:

1. Any program staff member who provided the client with the written instruction.

## COMPLIANCE REQUIREMENTS:

1. Completed with all new adult clients and emancipated minors at first face to face contact.
2. Check appropriate boxes to reflect:
  - a. Informed of Right to have Advanced Directive
  - b. Advanced Directive brochure was offered
  - c. If client has an executed Advanced Directive
  - d. Advanced Directive has been placed in medical record when provided by the client.
  - e. Informed that complaints may be filed with:
    - i. California Department of Health Services, Licensing and Certification Division at P.O. Box 997413, Sacramento, CA 95899-1413; or
    - ii. 1-800-236-9747.
3. Inform client of right to have AD placed in Medical Record.
4. Staff member who advises client of AD shall sign and date the form.
5. T Bar shall include the client's name, case number, and program name.

## DOCUMENTATION STANDARDS:

1. Form shall be legibly handwritten on Advance Directive Advise ment form (MHS-611).
2. Purpose is to provide clients with written information concerning their rights under federal and state law regarding Advance Medical Directives

## ADVANCE DIRECTIVE ADVISEMENT

Code of Federal Regulations (CFR) Chapter IV, Part 489.100 defines Advance Directives as: “a written instruction, such as living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.”

CRF Section 422.128 requires that all “M+C organizations” maintain written policies and procedures to meet the requirements of informing all adult individuals and emancipated minors receiving medical care by or through the M+C organization about advance directives. This information must reflect consequent changes in State law, no later than 90 days after the effective date of the State law.

As of June 1, 2004 Federal Regulations requires that all NEW adult clients (18 years and older) and emancipated minors be informed of their right to have an Advance Directive (AD). Therefore all clients who turn 18 or become emancipated after June 1, 2004 shall be informed of their right to have an AD. This physical health AD allows the individual to outline the kind of healthcare treatment they want, and who can speak on their behalf when they are not able to communicate their wishes. See County of San Diego Advance Directives Policy and Procedure Number 01-01-130.

Informed client of right to have an Advance Directive: Yes No

Offered Advance Directive Brochure: Yes No

Client has been informed that complaints concerning noncompliance with AD requirements may be filed with: California Department of Health Services  
Licensing and Certification Division Yes No  
P.O. Box 997413  
Sacramento, CA 95899-1413  
1-800-236-9747

Does client have an executed Advance Directive: Yes No Client did not disclose

Informed client of right to have AD placed in medical record: Yes No

Provided AD shall be attached to this form and placed in client’s medical record in Medical Section.

Staff Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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County of San Diego -CMHS

**ADVANCE DIRECTIVE ADVISEMENT**  
HHS:MHS-611 (3/2005)

**Client:** \_\_\_\_\_

**Case #:** \_\_\_\_\_

**Program:** \_\_\_\_\_

### Arabic

#### معلومات العميل

اسم العائلة:	الاسم الأول:	الاسم الأوسط:
رقم الحالة:	رقم التأمين الاجتماعي:	تاريخ الميلاد:

#### كيف يمكننا الوصول إليك؟

رقم الهاتف:	العنوان:	المدينة/الدولة:	الرمز البريدي:
إذا لم تكن أنت العميل:			اكتب اسمك:
بين علاقتك بالعميل:			

#### من يمكنه مشاركة المعلومات:

اسم الشخص أو الكيان:	رقم الهاتف:
العنوان:	المدينة/الدولة:
الرمز البريدي:	
الغرض من الطلب:	

#### من يمكنه تلقي المعلومات

اسم الشخص أو الكيان:	رقم الهاتف:
العنوان:	المدينة/الدولة:
الرمز البريدي:	

#### ما المعلومات التي يمكن مشاركتها

سجلات الفواتير	<input type="checkbox"/>	سجلات الفواتير	<input type="checkbox"/>
السجل المكتمل	<input type="checkbox"/>	نتائج المختبر	<input type="checkbox"/>
معلومات التشخيص	<input type="checkbox"/>	معلومات الدواء	<input type="checkbox"/>
سجلات الإعفاء	<input type="checkbox"/>	سجلات الصحة العقلية	<input type="checkbox"/>
معلومات علاج إدمان الكحول/المخدرات	<input type="checkbox"/>	الصور/الفيديوهات	<input type="checkbox"/>
نتائج اختبار الدم لكشف فيروس نقص المناعة	<input type="checkbox"/>	معلومات العلاج/الخدمة	<input type="checkbox"/>
البشرية (HIV)/الإيدز (AIDS) وأي/كل المراجع لها	<input type="checkbox"/>	أخرى:	<input type="checkbox"/>

## Arabic p2

### ماذا يعني تصريحك

**المعلومات الحساسة:** قد تشمل السجلات على معلومات تتعلق بالأمراض التي تنتقل جنسياً، أو متلازمة نقص المناعة المكتسب (AIDS)، أو فيروس نقص المناعة البشرية (HIV). كما قد تشمل معلومات بخصوص خدمات الصحة السلوكية أو العقلية أو علاج إدمان الكحول أو المخدرات.

**الحق في الإلغاء:** يحق لك إلغاء هذا التصريح في أي وقت. وإذا أردت إلغاء التصريح، يتعين عليك إلغائه كتابياً. ولن يسري هذا الإلغاء على المعلومات التي تم كشفها بالفعل.

**فترة الكشف عن المعلومات:** يمكنك تحديد تاريخ البدء و/أو تاريخ الانتهاء (أو الحدث) لمدة سريان التصريح. وهذا يعني أن السجلات لن تتم مشاركتها إلا بين التواريخ التي تحددها.

سيبدأ هذا التصريح في تاريخ البدء التالي: \_\_\_\_\_

• إذا لم يتم تحديد تاريخ بدء، فسوف يبدأ سريان هذا التصريح في تاريخ توقيعه.

سيينتهي هذا التصريح في تاريخ الانتهاء أو الحدث التالي: \_\_\_\_\_

• إذا لم يتم تحديد تاريخ انتهاء أو حدث، فسيينتهي هذا التصريح بعد عام واحد (1) من تاريخ توقيعه.

**إعادة الكشف عن المعلومات:** إذا صرّحت بكشف المعلومات الصحية المحمية لشخص معين غير مطالب من الناحية القانونية بالحفاظ على سريتها، فقد يُكشف عنها مرة أخرى ولن تعد محمية.

الحقوق الأخرى:

1. التصريح بالكشف عن هذه المعلومات أمر طوعي. ويمكنك رفض التوقيع على هذا التصريح. ولا يتعين عليك التوقيع على هذا النموذج لتلقي العلاج. ولكن، إذا كانت هناك حاجة إلى هذا التصريح للمشاركة في دراسة بحثية، فقد يُرفض التسجيل في الدراسة البحثية.

2. يمكنك مراجعة المعلومات المطلوب استخدامها أو الكشف عنها أو الحصول على نسخة منها، وذلك وفقاً لما هو منصوص عليه في الكود 45 من قسم اللوائح الفيدرالية 164-524.

3. يحق لك الحصول على نسخة من هذا التصريح. هل ترغب في الحصول على نسخة من هذا التصريح؟  نعم  لا

4. لمزيد من المعلومات حول حقوقك المتعلقة بالخصوصية، راجع إشعار ممارسات الخصوصية في موقعنا على شبكة الويب: [www.cosdcompliance.org](http://www.cosdcompliance.org) أو اتصل بمسؤول الخصوصية على الرقم 619-338-2808 أو على العنوان (PO Box 865524, San Diego, CA 92186-5524).

### التوقيع

التوقيع:

التاريخ:

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION – PARENT**  
**I hereby authorize use or disclosure of the named individual’s health information**

		TODAY’S DATE:	
<b>CLIENT</b>			
LAST NAME:		FIRST NAME:	INITIAL:
ADDRESS:		CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	SSN:	DATE OF BIRTH:	
AKA’s:			
<b>THE FOLLOWING INDIVIDUAL OR ORGANIZATION IS AUTHORIZED TO MAKE THE DISCLOSURE.</b>			
NAME OR ENTITY: ALL HEALTH AND EDUCATION PROVIDERS, MEDICAL, DENTAL, MENTAL HEALTH AND VISION			
TREATMENT DATES: ALL		PURPOSE OF REQUEST: PURSUANT TO WIC 16010	
<b>THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING ORGANIZATION:</b>			
NAME OF ENTITY: COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY CHILD WELFARE SERVICES			
ADDRESS		CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:		DATE:	
<b>THE FOLLOWING INFORMATION IS TO BE DISCLOSED:</b>			
<input checked="" type="checkbox"/> All records including, but not limited to: History and Physical Examination Discharge Summary CWS Treatment Plans/Treatment Plan Updates (psychotherapy) Medication Records Interpretation of images: x-rays, sonograms, etc. Laboratory results Dental records Psychiatric and psychological records including consultations HIV/AIDS blood test results; any/all references to those results Physician Orders Pharmacy records Immunization Records Nursing Notes Drug/Alcohol Rehabilitation Records All Education records			
<b>Sensitive Information:</b> I understand that the information in my child’s record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.			
<b>Right to Revoke:</b> I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing to the Social Worker. I understand that the revocation will not apply to information that has already been released based on this authorization.			

**Expiration:** Unless otherwise revoked, this authorization will expire on the following date, event, or condition (parent to initial one):

- \_\_\_\_\_ Upon termination of court jurisdiction or
- \_\_\_\_\_ Upon termination of voluntary placement agreement.

If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed.

**Redisclosure:** If I have authorized the disclosure of my child’s health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my child’s health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

**Other Rights:** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. However, for children who are dependents of the Juvenile Court, the Agency will request the Court to order the release this information.

I understand that Title 45 Code of Federal Regulations section 164.524 may provide me with the right to obtain from my child’s medical provider copies of the information to be used or disclosed pursuant to this authorization.

For children in protective custody: I understand that the information contained in my child’s health records is needed by HHSa for the purpose of determining the medical, developmental, dental and mental health status of my child to plan for his/her care, while not in my custody. I understand that HHSa may use this information to determine if my child should be made, or continued as a dependent of the Juvenile Court; whether my child should be removed from my custody and control, and if removed, to evaluate my progress in working to regain custody of my child.

I further understand that pursuant to the Welfare and Institutions Code and Superior Court Rules, my child’s health and education information will be shared with substitute caregivers, health and education providers, and officers of the Court or other parties in a dependency action in the Juvenile Court, or in subsequent proceedings to appoint a legal guardian or terminate the parental rights entirely.

I have received a copy of this authorization.  Yes  No

**SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE**

SIGNATURE:	DATE:
------------	-------

RELATIONSHIP TO INDIVIDUAL:

**CLIENT'S INFORMATION**

LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
CASE NUMBER:	SSN:	DATE OF BIRTH:

**HOW DO WE REACH YOU?**

PHONE NUMBER:	ADDRESS:	CITY/STATE:	ZIP CODE:
---------------	----------	-------------	-----------

**IF YOU ARE NOT THE CLIENT:**

PRINT YOUR NAME:	INDICATE YOUR RELATIONSHIP TO CLIENT:
------------------	---------------------------------------

**WHO MAY SHARE THE INFORMATION:**

NAME OF PERSON OR ENTITY:	PHONE NUMBER:
ADDRESS	CITY/STATE: ZIP CODE:
PURPOSE OF REQUEST:	

**WHO MAY RECEIVE THE INFORMATION**

NAME OF PERSON OR ENTITY:	PHONE NUMBER:
ADDRESS	CITY/STATE: ZIP CODE:

**WHAT INFORMATION MAY BE SHARED**

<input type="checkbox"/> Billing Records	<input type="checkbox"/> Immunization Records
<input type="checkbox"/> Complete Record	<input type="checkbox"/> Laboratory Results
<input type="checkbox"/> Diagnosis Information	<input type="checkbox"/> Medication Information
<input type="checkbox"/> Discharge Records	<input type="checkbox"/> Mental Health Records
<input type="checkbox"/> Drug/Alcohol Treatment Information	<input type="checkbox"/> Photos/Videos
<input type="checkbox"/> HIV/AIDS blood test results and any/all references to those	<input type="checkbox"/> Treatment/Service Information
	<input type="checkbox"/> Other: _____

**WHAT YOUR AUTHORIZATION MEANS**

**Sensitive Information:** Records may include information relating to sexually transmitted diseases, Acquired Immunodeficiency Syndrome (AIDS), or the Human Immunodeficiency Virus (HIV). They may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

**Right to Revoke:** You have the right to revoke this authorization at any time. If you revoke this authorization, you must do so in writing. Your revocation will not apply to information that has already been released.

**Period of Disclosure:** You can provide a start and/or end date (or event) for the authorization to be in effect. This means records will only be shared between the dates you specify.

This authorization will begin on the following Start Date: \_\_\_\_\_

- If no Start Date is specified, this authorization will be effective on the date signed.

This authorization will expire on the following End Date or Event: \_\_\_\_\_

- If no End Date or Event is specified, this authorization will expire one (1) calendar year from the date signed.

**Redisclosure:** If you have authorized protected health information to be disclosed to someone who is not legally required to keep it confidential, it may be redisclosed and will no longer be protected.

**Other Rights:**

1. Authorizing the disclosure of this information is voluntary. You can refuse to sign this authorization. You do not need to sign this form to receive treatment. However, if this authorization is needed for participation in a research study, enrollment in the research study may be denied.
2. You may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section 164.524.
3. You have right to receive a copy of this authorization. Would you like a copy of this authorization?  Yes  No
4. For more information about your privacy rights, see the Notice of Privacy Practices on our website: [www.cosdcompliance.org](http://www.cosdcompliance.org) or contact the Privacy Officer at 619-338-2808 or at PO Box 865524, San Diego, CA 92186-5524.

**SIGNATURE**

SIGNATURE:

DATE:

**COMPLETED BY:**

1. Staff member who identifies need to request or exchange information on behalf of the client.

**COMPLIANCE REQUIREMENTS:**

1. Required for all clients when an exchange of information with another party is warranted.
2. The following areas are required:
  - a. Current date.
  - b. Client information which includes: last name, first name, middle initial, address, city/state, zip code, telephone number, SSN (optional), DOB, and any AKA's.
  - c. Individual or organization authorized to make disclosure.
  - d. Individual or organization to whom the information may be disclosed to and used by.
  - e. Type of information to be disclosed.
  - f. Start date and Expiration date
  - g. Signature of client or legal representative/guardian with date.
3. County Providers shall use the approved County Form (23-07 HHSA). Contracted Providers may choose to use this form as well, but need to include their own logo and Program Information in the header. Contracted providers are to seek their own legal counsel regarding authorization and appropriate forms.

**DOCUMENTATION STANDARDS:**

1. Clients who are 18 years of age or older or emancipated may sign for their own authorization.
2. Additionally, under some circumstances a minor 12 years and older may sign for authorization (see Welfare and Institutions Code 14010 and Family Code 6924, 6929, 7050).
3. For Dependents of the Court, an ex-parte or court order may be utilized to authorize use or disclosure of protected health information.
  - a. Authorization to Use or Disclose Protected Health Information – Parent (number 04-24A-P and dated 06/13) is generated by the Child Welfare Services worker for the parent / guardian to sign for the purpose of disclosing protected health information to the Child Welfare Services worker.
  - b. Order for Release of Protected Health and Education Information (number 04-24A-C and dated 06/13) is generated by the Courts for the purpose of disclosing protected health information to the Child Welfare Services worker.
4. Completed forms are to be kept in the hybrid chart.

**INFORMACIÓN DEL CLIENTE**

APELLIDO(S):	PRIMER NOMBRE:	INICIAL SEGUNDO NOMBRE:
NÚMERO DE CASO:	NÚMERO DE SEGURIDAD SOCIAL (SSN):	FECHA DE NACIMIENTO:

**¿CÓMO PODEMOS CONTACTAR CON USTED?**

NÚMERO DE TELÉFONO:	DIRECCIÓN:	CIUDAD/ESTADO:	CÓDIGO POSTAL:
---------------------	------------	----------------	----------------

**SI USTED NO ES EL CLIENTE?**

ESCRIBA SU NOMBRE CON LETRA DE MOLDE:	INDIQUE LA RELACIÓN QUE TIENE CON EL CLIENTE:
---------------------------------------	---

**QUIÉN PUEDE COMPARTIR LA INFORMACIÓN:**

NOMBRE DE LA PERSONA O ENTIDAD:	NÚMERO DE TELÉFONO:	
DIRECCIÓN:	CIUDAD/ESTADO:	CÓDIGO POSTAL:
PROPÓSITO DE LA SOLICITUD:		

**QUÉ INFORMACIÓN SE PUEDE COMPARTIR**

<input type="checkbox"/> Registros de facturación	<input type="checkbox"/> Registros de vacunas
<input type="checkbox"/> Todo el expediente	<input type="checkbox"/> Resultados de laboratorio
<input type="checkbox"/> Información de diagnóstico	<input type="checkbox"/> Información médica
<input type="checkbox"/> Registros de egreso	<input type="checkbox"/> Registros de salud mental
<input type="checkbox"/> Información de tratamiento de drogas/alcohol	<input type="checkbox"/> Fotos/videos
<input type="checkbox"/> Resultados de pruebas sanguíneas de VIH/SIDA y cualquier/toda referencia a los mismos	<input type="checkbox"/> Información de tratamiento/servicios
	<input type="checkbox"/> Otro: _____

### EL SIGNIFICADO DE SU AUTORIZACIÓN

**Información confidencial:** Los registros pueden incluir información relacionada con enfermedades transmitidas sexualmente, síndrome de inmunodeficiencia adquirida (SIDA) o infección con el virus de inmunodeficiencia humana (VIH), información sobre servicios de salud mental o de comportamiento o tratamiento contra el abuso de alcohol y drogas.

**Derecho a la revocación:** Usted tiene el derecho a revocar esta autorización en cualquier momento. Si usted revoca esta autorización, lo debe hacer por escrito. Su revocación no se aplicará a la información que ya haya sido divulgada.

**Plazo de divulgación:** Usted puede proporcionar una fecha de inicio y/o final (o evento) para la cual será válida la autorización. Esto quiere decir que los registros solamente se compartirán entre las fechas que usted especifique.

Esta autorización será válida a partir de la siguiente fecha inicial: \_\_\_\_\_

- Si no se especifica una fecha inicial, será válida a partir de la fecha en que se firmó.

Esta autorización se vencerá en la siguiente fecha final o evento: \_\_\_\_\_

- Si no se especifica fecha final o evento, esta autorización se vencerá en un (1) año civil a partir de la fecha en que se firmó.

**Divulgación por terceros:** Si yo he autorizado la divulgación de mi información protegida de salud a alguien que no está legalmente obligado a mantenerla con carácter confidencial, puede divulgarse a terceros y ya no será información protegida.

**Otros derechos:**

1. La autorización de divulgación de esta información es voluntaria. Usted puede negarse a firmar esta autorización. Usted no tiene que firmar este formulario para recibir tratamiento. Sin embargo, si esta autorización es necesaria para participar en un estudio de investigación, puede que se le niegue la inscripción al estudio.
2. Usted puede inspeccionar u obtener una copia de la información que se usará o divulgará, establecido en la sección 164.524 / código 45 de las Reg. Federales.
3. Usted tiene el derecho a recibir una copia de esta autorización. ¿Desea una copia de esta autorización?  Sí  No
4. Para obtener información adicional, consulte El Aviso de las Prácticas de Privacidad en nuestro sitio en línea: [www.cosdcompliance.org](http://www.cosdcompliance.org) o póngase en contacto con el Funcionario de Privacidad llamando al 619-338-2808 o escribiendo a PO Box 865524, San Diego, CA 92186-5524.

### FIRMA

FIRMA:

FECHA:

**IMPORMASYON TUNGKOL SA KLIYENTE**

APELYIDO:	PANGALAN:	INISYAL NG GITNANG PANGALAN:
NUMERO NG KASO:	SSN:	PETSA NG KAPANGANAKAN:

**PAANO KAMI MAAARING MAKIPAG-UGNAYAN SA INYO?**

NUMERO NG TELEPONO:	ADDRESS:	LUNGSOD / ESTADO:	ZIP CODE:
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**KUNG HINDI KAYO ANG KLIYENTE:**

I-PRINT ANG INYONG PANGALAN:	IPAHAYAG ANG INYONG RELASYON SA KLIYENTE:
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**SINO ANG MAAARING MAGBAHAGI NG IMPORMASYON:**

PANGALAN NG TAO O ENTITY:	NUMERO NG TELEPONO:	
ADDRESS	LUNGSOD / ESTADO:	ZIP CODE:
LAYUNIN NG KAHILINGAN:		

**ANONG IMPORMASYON ANG MAAARING IBAHAGI**

<input type="checkbox"/> Mga Billing Record	<input type="checkbox"/> Mga Rekord ng Bakuna
<input type="checkbox"/> Kumpletong Rekord	<input type="checkbox"/> Mga Resulta ng Laboratoryo
<input type="checkbox"/> Impormasyon sa Diagnosis	<input type="checkbox"/> Impormasyon Tungkol sa Medikasyon
<input type="checkbox"/> Mga Rekord sa Pagpapalabas	<input type="checkbox"/> Mga Rekord Tungkol sa Kalusugang Pangkaisipan
<input type="checkbox"/> Impormasyon sa Paggagamot sa Droga/Alak	<input type="checkbox"/> Mga Litrato/Videos
<input type="checkbox"/> Mga resulta ng blood test para sa HIV/AIDS at anumang/lahat ng mga sumasangguni doon	<input type="checkbox"/> Impormasyon sa Paggagamot/Serbisyo
	<input type="checkbox"/> Iba pa: _____

**ANO ANG KAHULUGAN NG INYONG AWTORISASYON**

**Sensitibong Impormasyon:** Ang mga rekord ay maaaring may kasamang mga impormasyon na may kaugnayan sa mga sexually transmitted na sakit, Acquired Immunodeficiency Syndrome (AIDS), o Human Immunodeficiency Virus (HIV). Maaaring kasama rin dito ang impormasyon tungkol sa pag-uugali o kalusugang pangkaisipan na serbisyo o paggagamot para sa pagkagumon sa alak at droga.

**Karapatan na Tanggalin:** Kayo ay may karapatan na bawiin ang awtorisasyon na ito anumang oras. Kung bawiin ninyo ang awtorisasyon na ito, kailangan ninyong gawin ito sa pamamagitan ng kasulatan. Ang inyong pagbawi ay hindi gagamitin sa impormasyon na ipinalabas na.

**Panahon ng Pagpapahayag:** Maaari kayong magkaloob ng isang petsa ng pagsisimula at/o pagtatapos (o pangyayari) kung kailan magkakabisa ang awtorisasyon. Ito ay nangangahulugan na ang mga rekord ay ibabahagi lang sa pagitan ng mga petsa na inyong tinukoy.

Ang awtorisasyon na ito ay magsisimula sa sumusunod na Petsa ng Pagsisimula: \_\_\_\_\_

- Kung walang tiniyak na Petsa ng Pagsisimula, ang awtorisasyon na ito ay magkakabisa sa petsa na ito ay nilagdaan.

Ang awtorisasyon na ito ay magwawakas sa susunod na Petsa ng Katapusan o Pangyayari:

- Kung walang tinukoy na Petsa ng Katapusan o Pangyayari, ang awtorisasyon na ito ay magwawakas sa loob ng isang (1) taon na base sa kalendaryo mula nang malagdaan.

**Muling pagbubunyag:** Kung pinahintulutan ninyo ang pagbubunyag ng protektadong impormasyong pangkalusugan sa ibang tao na hindi legal na inaatasan na mapanatili itong kompidensyal, maaari itong muling ibunyag at hindi na mapoprotektahan.

**Iba pang Mga Karapatan:**

1. Ang pagpapahintulot sa pagpapahayag ng impormasyong ito ay kusang loob. Maaari ninyong tanggihan na lagdaan ang awtorisasyon na ito. Hindi ninyo kailangang lagdaan ang form na ito para makakuha ng paggagamot. Gayunman, kung ang awtorisasyon na ito ay kailangan para sa pagsali sa isang pag-aaral na pananaliksik, maaaring matanggihan ang enrollment sa pag-aaral na pananaliksik.
2. Maaari kayong magsuri o kumuha ng kopya ng impormasyong gagamitin o ipapahayag, ayon sa nakasaad sa 45 Code of Federal Regulations seksyon 164.524.
3. Mayroon kayong karapatan na tumanggap ng kopya ng awtorisasyon na ito. Nais ba ninyo ng kopya ang awtorisasyon na ito?  Oo  Hindi
4. Para mga karagdagang impormasyon tungkol sa inyong mga karapatan sa privacy, tingnan ang Paunawa sa Mga Pamamalakad sa Privacy sa aming website: [www.cosdcompliance.org](http://www.cosdcompliance.org) o makipag-ugnayan sa Privacy Officer sa 619-338-2808 o sa PO Box 865524, San Diego, CA 92186-5524.

**LAGDA**

LAGDA:

PETSA:

**CHI TIẾT VỀ THÂN CHỦ**

HỌ:	TÊN:	TÊN ĐỆM TẮT:
SỐ HỒ SƠ:	SSN:	NGÀY SINH:

**CHÚNG TÔI LIÊN LẠC VỚI QUÝ VỊ BẰNG CÁCH NÀO?**

SỐ ĐIỆN THOẠI:	ĐỊA CHỈ:	THÀNH PHỐ/TIỂU BANG:	SỐ ZIP:
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**NẾU QUÝ VỊ KHÔNG PHẢI LÁ THÂN CHỦ:**

VIẾT TÊN CỦA QUÝ VỊ THEO KIỂU CHỮ IN:	LIÊN HỆ CỦA QUÝ VỊ VỚI THÂN CHỦ:
---------------------------------------	----------------------------------

**AI CÓ THỂ TIẾT LỘ CHI TIẾT:**

TÊN NGƯỜI HOẶC THỰC THỂ:	SỐ ĐIỆN THOẠI:	
ĐỊA CHỈ	THÀNH PHỐ/TIỂU BANG:	SỐ ZIP:
MỤC ĐÍCH CỦA YÊU CẦU:		

**CHI TIẾT NÀO CÓ THỂ ĐƯỢC PHÉP TIẾT LỘ**

<input type="checkbox"/> Sổ Sách Hóa Đơn	<input type="checkbox"/> Hồ Sơ Chủng Ngừa
<input type="checkbox"/> Hồ Sơ Đầy Đủ	<input type="checkbox"/> Kết Quả Thử Nghiệm
<input type="checkbox"/> Chi Tiết Chẩn Đoán	<input type="checkbox"/> Chi Tiết Về Thuốc Men
<input type="checkbox"/> Hồ Sơ Xuất Viện	<input type="checkbox"/> Hồ Sơ Sức Khỏe Tâm Thần
<input type="checkbox"/> Chi Tiết Điều Trị Ma Túy/Rượu Bia	<input type="checkbox"/> Hình Ảnh/Video
<input type="checkbox"/> Kết quả thử máu để tìm HIV/AIDS và mọi đề cập đến những kết quả đó	<input type="checkbox"/> Chi Tiết Về Chữa Trị/Dịch Vụ
	<input type="checkbox"/> Chi Tiết Khác: _____

### QUYẾT ĐỊNH CHO PHÉP CỦA QUÝ VỊ CÓ Ý NGHĨA GÌ

**Chi Tiết Tế Nhị:** Hồ sơ có thể bao gồm chi tiết liên quan đến các chứng bệnh phong tình, Hội Chứng Khiếm Khuyết Khả Năng Miễn Nhiễm Từ Ngoài (AIDS), hoặc Siêu Vi Khuẩn Gây Khiếm Khuyết Khả Năng Miễn Nhiễm Ở Người (HIV). Hồ sơ cũng có thể bao gồm chi tiết về các dịch vụ sức khỏe hành vi hoặc tâm thần hoặc điều trị tình trạng lạm dụng rượu bia và ma túy.

**Quyền Hủy Bỏ:** Quý vị có quyền hủy bỏ giấy cho phép này bất cứ lúc nào. nếu quý vị hủy bỏ giấy cho phép này, quý vị phải viết thư thông báo. Việc hủy bỏ của quý vị sẽ không áp dụng cho những chi tiết đã được tiết lộ.

**Giai Đoạn Tiết Lộ:** Quý vị có thể quy định ngày (hoặc biến cố) bắt đầu và/hoặc hết hiệu lực của giấy phép này. Điều này có nghĩa là hồ sơ sẽ chỉ được tiết lộ cho thời gian quý vị quy định. Việc cho phép này sẽ bắt đầu vào Ngày Bắt Đầu sau đây: \_\_\_\_\_

- Nếu Ngày Bắt Đầu không được quy định, việc cho phép này sẽ có hiệu lực vào ngày ký tên. Việc cho phép này sẽ hết hạn vào Ngày Chấm Dứt hoặc Biến Cố: \_\_\_\_\_
- Nếu Ngày Chấm Dứt hoặc Biến Cố không được quy định, việc cho phép này sẽ hết hạn sau một (1) năm tính từ ngày ký tên.

**Tiết Lộ Tiếp:** Nếu quý vị đã cho phép tiết lộ chi tiết sức khỏe được bảo vệ cho một người không bị luật pháp bắt buộc phải giữ kín, chi tiết đó có thể được tiết lộ tiếp và sẽ không còn được bảo vệ nữa.

#### Các Quyền Khác:

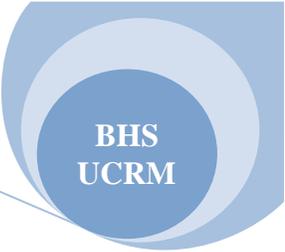
1. Việc cho phép tiết lộ chi tiết này là tự nguyện. Quý vị có thể từ chối ký tên vào giấy cho phép này. Quý vị không cần ký tên vào mẫu đơn này để được chữa trị. Tuy nhiên, nếu cần phải có giấy cho phép để tham gia trong một cuộc nghiên cứu, thì việc ghi danh tham gia cuộc nghiên cứu có thể bị từ khước.
2. Quý vị có thể xem xét hoặc xin một bản ghi các chi tiết được sử dụng hoặc tiết lộ, như đã được quy định trong 45 Bộ Luật về Các Điều Lệ Của Liên Bang đoạn 164.524.
3. Quý vị có quyền giữ một bản sao của giấy cho phép này. Quý vị có muốn một bản sao của giấy cho phép này không?  Có  Không
4. Muốn biết thêm chi tiết về các quyền riêng tư của mình, hãy xem Thông Báo về Những Cách Tôn Trọng Quyền Riêng Tư trên website của chúng tôi: [www.cosdcompliance.org](http://www.cosdcompliance.org) hoặc liên lạc với Viên Phụ Trách Quyền Riêng Tư ở số 619-338-2808 hoặc tại địa chỉ PO Box 865524, San Diego, CA 92186-5524.

### CHỮ KÝ

CHỮ KÝ:

NGÀY:

## Consent For Services (County Form)

The logo for BHS UCRM is located in the top right corner. It consists of three overlapping circles in shades of blue, with the text "BHS" above "UCRM" in white, centered within the innermost circle.

BHS  
UCRM

### **COMPLETED BY:**

1. Client
2. Parent/Guardian
3. Staff member admitting the client

### **COMPLIANCE REQUIREMENTS:**

1. All areas and fields shall be addressed.
2. Completed on first face to face contact with client.

### **DOCUMENTATION STANDARDS:**

1. This form is required for all County programs. Contracted programs, as approved through their legal counsel/legal entity, may use their own Consent to Services forms.

**CONSENT FOR SERVICES**  
**COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES**

CONSENT FOR: \_\_\_\_\_

PROGRAM NAME: \_\_\_\_\_

The County of San Diego Behavioral Health Services (BHS) provides mental health and substance use care. When you receive services, you will be asked questions about mental health and substance use. The process of asking and answering these questions is called an assessment. Understanding your needs helps us create a plan of care together. Our plan is based on knowing your strengths and challenges and will include services and actions you and important people in your life can take to feel better. We invite you to partner with us to improve your health and wellness to create a Healthy, Safe and Thriving life.

**CONSENT FOR SERVICES**

Consent for services means you understand the kinds of services that are available to you at this program. Services authorized by this Consent will be based on your needs and what you say is important. You help decide which services you receive. The kinds of services are:

- Assessment and screening about mental health and/or substance use
- Counseling (in a group/or individual) for mental health and/or substance use
- Case Management services (finding resources to help you)
- Medication services
  - Meeting with a doctor and/or nurse about medications. This may include getting resources for physical health needs or laboratory tests to help your doctor monitor your health or medications.
- Other services that help you achieve your goals

Services can be provided in person (face to face) or by phone. They can also be done by telepsychiatry, which means meeting with a psychiatrist through a video screen system. Services may be provided by a medical doctor, nurse, counselor, family/peer support partner, student intern or other staff.

I understand that I have the right:

- to have questions and answers explained about my diagnosis and care
- to get a copy of this Consent

**CONSENT FOR SERVICES**  
County of San Diego  
Health and Human Services Agency  
Behavioral Health Services (BHS)  
Adult/Older Adult and CYF Programs

HHSA:BHS (06-01-15)

**Client Name:** \_\_\_\_\_

**Client Record ID #:** \_\_\_\_\_

**Program:** \_\_\_\_\_

- to end this Consent at any time
- to have the doctor discuss with me the benefits and risks of medications
- to file a complaint or grievance without negative consequences

**Important Information:**

- The law requires that BHS notify the individual and the authorities if you have the intention to harm another individual.
- The law requires that we report any suspected child abuse, neglect, or molestation to protect minors. Also, suspected cases of dependent adult and elder abuse are reported. We will make every effort to help you understand your situation and explain why we are required to make these reports.
- The law requires that if there are serious concerns of death by suicide, or if you become unable to care for yourself, we have to tell the authorities to arrange for hospitalization. We will make every effort to do this with you so that we can understand your situation and explain why we are required to make these reports
- When health insurance pays for your services, information about your services may be shared between your provider and the insurance company.
- A minor who is 12 years of age or older may consent to behavioral health services if the minor is mature enough to participate in mental health/substance use disorder services.

San Diego County BHS believes in your total health and wellness.

- Our program sites are safe and free from alcohol and illegal drugs
- We want to know what is supportive to you (like music, exercise, friends, family)
- Services may not be available 7 days a week 24 hours a day. You can call the Access and Crisis Line at 1-888-724-7240, 24 hours a day. In an emergency, call 911, or go to the nearest emergency room. We can help you with a plan.

I have read or had this form read or explained to me. I understand this information and agree to accept services. This consent will end when I state it should end and/or when my current services end.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT FOR SERVICES**  
 County of San Diego  
 Health and Human Services Agency  
 Behavioral Health Services (BHS)  
 Adult/Older Adult and CYF Programs

HHSA:BHS (06-01-15)

**Client Name:** \_\_\_\_\_

**Client Record ID #:** \_\_\_\_\_

**Program:** \_\_\_\_\_

## موافقة مستنيرة لتعاطي دواء عقلي

### حقوق العميل

- إن لديك الحق في الحصول على معلومات حول رعايتك وأن تتمكن من طرح الأسئلة.
  - إن لديك الحق في قبول أو رفض أي من خطة رعايتك أو كلها.
  - إن لديك الحق في إنهاء موافقتك شفهيًا أو كتابيًا لأي عضو في فريق العمل في أي وقت.
  - إن لديك الحق في الحصول على خدمات اللغة/الترجمة الشفهية.  نعم  لا هل هناك خدمات مطلوبة؟
  - إن لديك الحق في الحصول على نسخة من هذه الموافقة:  نعم  لا هل تم طلب نسخة؟
- علاج الطوارئ (الحالة الطارئة عبارة عن تغيير مؤقت ومفاجئ ومحدد يتطلب التصرف للحفاظ على الحياة أو للوقاية من الضرر الجسدي الخطير سواء للعميل أو الآخرين):** في حالات طوارئ معينة، قد يتم إعطاؤك دواءً حين لا يكون من الممكن الحصول على موافقتك. إلا أنه ما أن يتم تجاوز الحالة الطارئة، سيكون من اللازم الحصول على موافقتك المستنيرة.

### سيناقش معك طاقم طبي المعلومات أدناه:

1. طبيعة وخطورة مرضك العقلي
2. أسباب الأدوية بما في ذلك احتمال التحسن أو عدم التحسن مع الأدوية أو بدونها
3. العلاجات البديلة المنطقية وسبب توصية الطبيب بهذا العلاج تحديداً وثق البديل، إذا انطبق الأمر:
4. نوع الدواء وجرعته وعدد مرات تعاطيه ومدة التعاطي وطريقة تعاطي الأدوية
5. الآثار الجانبية الشائعة المعروفة التي يمكن أن تصاب بها:  العصبية  تشوش الرؤية  الإمساك/الإسهال  جفاف الفم  صعوبة التنفس
6. الآثار الجانبية الإضافية الممكنة التي يمكن أن تحدث عند تعاطي الأدوية لمدة تتجاوز ثلاثة شهور
7. إذا كنت تتعاطى مضاد ذهان تقليدي أو غير تقليدي، سيتم إعطاؤك معلومات حول أثر جانبي محتمل يعرف باسم خلل الحركة المتأخر. ويتسم بحركات غير طوعية في الوجه، الفم، و/أو اليدين والقدمين. يحتمل أن تكون هذه الأعراض غير قابلة للتراجع وقد تظهر بعد التوقف عن تعاطي الدواء.

هل تم شرح المعلومات أعلاه للعميل؟  نعم  لا إذا كانت الإجابة لا، وثق السبب.

### يصف الطاقم الطبي الأدوية العقلية التالية لك:

الدواء (الاسم)	نطاق الجرعة (كم)	التكرار (عدد المرات)	المدة (لكم من الوقت)	عبر الفم (بجريه الطاقم الطبي) أو حقن (بجريه الطاقم الطبي)
				عبر الفم <input type="checkbox"/> حقنة <input type="checkbox"/>
				عبر الفم <input type="checkbox"/> حقنة <input type="checkbox"/>
				عبر الفم <input type="checkbox"/> حقنة <input type="checkbox"/>
				عبر الفم <input type="checkbox"/> حقنة <input type="checkbox"/>
				عبر الفم <input type="checkbox"/> حقنة <input type="checkbox"/>

هل تم تقديم ورقة معلومات الدواء لكل الأدوية العقلية؟  نعم  لا إذا كانت الإجابة لا، وثق السبب.

العميل: \_\_\_\_\_  
رقم الحالة: \_\_\_\_\_  
البرنامج: \_\_\_\_\_

مقاطعة سان دييغو

موافقة مستنيرة لتعاطي  
دواء عقلي  
صفحة 1 من 2

### موافقة العميل

بناءً على المعلومات التي قرأتها، ناقشتها و/أو راجعتها مع طاقمي الطبي:  
(ضع علامة على خيار واحد)

أنا أفهم وأقدم موافقتي على تعاطي الأدوية العقلية المدرجة في الصفحة الأولى.

أنا أقدم موافقة شفوية فقط وأرفض توقيع النموذج.

أنا لا أوافق على تعاطي الأدوية العقلية المدرجة أدناه.

يرجى ذكرها: \_\_\_\_\_

توقيع العميل/الممثل القانوني/الوصي

التاريخ

### بيان الطاقم الطبي

لقد راجعت وناقشت وأوصيت بخطة الدواء (الصفحة 1) للعميل أعلاه وقد:

قدم العميل موافقته على تعاطي هذه الأدوية.

قدم العميل موافقة شفوية ولكنه رفض أو كان لا يستطيع التوقيع.

الحالة الطارئة. تم إعطاء الدواء للعميل دون موافقته.

العميل لا يمكنه فهم المخاطر والفوائد ولهذا لا يمكنه الموافقة.

تعليقات أخرى:

توقيع وترخيص الطاقم الطبي

التاريخ

اسم وترخيص الطاقم الطبي

توقيع الشاهد (إذا انطبق الأمر):

التاريخ

العميل: \_\_\_\_\_

رقم الحالة: \_\_\_\_\_

البرنامج: \_\_\_\_\_

مقاطعة سان دييغو

موافقة مستنيرة لتعاطي

دواء عقلي

صفحة 1 من 2

## INFORMED CONSENT FOR TAKING PSYCHOTROPIC MEDICATION

### CLIENT RIGHTS

- You have the right to be informed about your care and to ask questions.
- You have the right to accept or reject any or your entire care plan.
- You have the right to end your consent verbally or in writing to any team member at any time.
- You have the right to language/interpreting services. *Services Requested?*  YES  NO
- You have the right to a copy of this Consent: *Copy Requested?*  YES  NO

**Emergency Treatment** (*An emergency is a temporary, sudden marked change requiring action to preserve life or prevent serious bodily harm to client or others*): In certain emergencies, medication may be given to you when it is not possible to get your consent. However, once the emergency has passed, your informed consent is required.

#### Medical staff will discuss with you the information below:

1. Nature and seriousness of your mental illness
2. Reason(s) for medication(s) including the likelihood of improving, or not improving with or without the medication(s)
3. Reasonable alternative treatments and why doctor is recommending this particular treatment. Document alternative, if applicable:
4. Medication type, dosage, frequency, duration, and method for taking medication(s)
5. Commonly known probable side effects that you may experience:
6. Possible additional side effects which may happen when taking medication(s) longer than three months:
7. If taking a typical or atypical anti-psychotic medication, you will be given information about a possible side effect called **tardive dyskinesia**. It is characterized by involuntary movements of the face, mouth and/or hands and feet. These symptoms are potentially irreversible and may appear after medication has been discontinued.

**Above information explained to client?**  YES  NO **If no, document reason.**

#### Medical staff is prescribing the following psychotropic medication(s) for you:

Medication (name)	Dosage Range (how much)	Frequency (how often)	Duration (how long)	Oral (by mouth) or Injection (by medical staff)
				<input type="checkbox"/> Oral <input type="checkbox"/> Injection
				<input type="checkbox"/> Oral <input type="checkbox"/> Injection
				<input type="checkbox"/> Oral <input type="checkbox"/> Injection
				<input type="checkbox"/> Oral <input type="checkbox"/> Injection
				<input type="checkbox"/> Oral <input type="checkbox"/> Injection

Medication information sheet given for all psychotropic medications?  YES  NO

**If no, document reason.**

County of San Diego

**INFORMED CONSENT FOR TAKING  
PSYCHOTROPIC MEDICATION**

Page 1 of 2

**Client:** \_\_\_\_\_

**Case #:** \_\_\_\_\_

**Program:** \_\_\_\_\_

**Client's Consent**

**Based on the information I have read, discussed and/or reviewed with my medical staff:**

(check one)

I understand and give consent to take the psychotropic medication(s) on page one.

I give verbal consent only; refuse to sign form.

I **do not** consent to take the psychotropic medication(s) listed below.

Please list: \_\_\_\_\_

\_\_\_\_\_  
Client/Legal Rep./Guardian Signature

\_\_\_\_\_  
Date

**Medical Staff Statement**

**I have reviewed, discussed and recommend the medication plan (page 1) for above client and:**

Client gives consent to take these medications.

Client gives verbal consent, but unwilling or unable to sign.

Emergency. Client given medication without consent.

Client unable to understand risks and benefits, and therefore cannot consent.

Other Comments:

\_\_\_\_\_  
Medical Staff Signature and License

\_\_\_\_\_  
Date

\_\_\_\_\_  
Medical Staff Printed Name and License

\_\_\_\_\_  
Witness Signature (if applicable):

\_\_\_\_\_  
Date

County of San Diego

**INFORMED CONSENT FOR TAKING  
PSYCHOTROPIC MEDICATION**

**Page 2 of 2**

**Client:** \_\_\_\_\_

**Case #:** \_\_\_\_\_

**Program:** \_\_\_\_\_

## DECLARACIÓN DE CONSENTIMIENTO INFORMADO PARA TOMAR MEDICAMENTOS PSICOTRÓPICOS

### DERECHOS DEL CLIENTE

- Usted tiene el derecho de mantenerse informado en relación a su cuidado y de hacer preguntas.
- Usted tiene el derecho de aceptar o rechazar cualquier parte de su plan de cuidado o todo el plan.
- Usted tiene el derecho de terminar su autorización de forma verbal o escrita ante cualquier miembro del equipo en cualquier momento.
- Usted tiene el derecho a recibir servicios de idiomas/interpretación. *¿Solicitó servicios?*  SÍ  NO
- Usted tiene el derecho a recibir una copia impresa de este consentimiento informado: *¿Solicitó una copia?*  
 SÍ  NO

**Tratamiento de emergencia** (*Una emergencia es una acción temporal, un cambio importante repentino que requiere de una acción para conservar la vida o evitar daños corporales graves al cliente o a otros*): En ciertas emergencias, se le podrían dar ciertos medicamentos cuando no es posible obtener su consentimiento. Sin embargo, una vez que pase la emergencia, entonces será necesario una declaración de consentimiento informado.

### El personal médico platicará con usted sobre la siguiente información:

1. Naturaleza y seriedad de su enfermedad mental.
  2. Razón o razones para el medicamento, entre las que se incluyen la probabilidad de mejoras o falta de mejoras, con o sin medicamentos.
  3. Tratamientos alternativos razonables y el por qué el doctor está recomendando este tratamiento en particular. Documentos alternos, si corresponden:
  4. Tipo de medicamento, dosis, frecuencia, duración y método para tomar el(los) medicamento(s).
  5. Posibles efectos secundarios comúnmente conocidos que podría experimentar:  agitación  visión borrosa  estreñimiento/diarrea  boca seca  dificultad para respirar
  6. Posibles efectos secundarios que podrían presentarse al tomar el(los) medicamento(s) por más de tres meses.
  7. Si está tomando medicamento antipsicótico típico o atípico, entonces se le dará información sobre un posible efecto secundario denominado **discinesia tardía**. Esta se caracteriza por movimientos involuntarios de la cara, la boca y/o las manos y pies. Estos síntomas son potencialmente irreversibles y pueden aparecer después de discontinuar el uso del medicamento.
- ¿Se explicó la información de arriba al cliente?*  SÍ  NO **Si no, documentar la razón.**

### El personal médico les está recetando el(los) siguiente(s) medicamento(s) psicotrópicos a usted:

Medicamento (nombre)	Rango de dosis (cuánto)	Frecuencia (qué tan a menudo)	Duración (por cuánto tiempo)	Oral (por la boca) o Por inyección (por el personal médico)
				<input type="checkbox"/> Oral <input type="checkbox"/> Inyección
				<input type="checkbox"/> Oral <input type="checkbox"/> Inyección
				<input type="checkbox"/> Oral <input type="checkbox"/> Inyección
				<input type="checkbox"/> Oral <input type="checkbox"/> Inyección
				<input type="checkbox"/> Oral <input type="checkbox"/> Inyección

*¿Se proporcionó hoja de información del medicamento para todos los medicamentos psicotrópicos?*  
 SÍ  NO

**Si no, documentar la razón.**

Condado de San Diego

**DECLARACIÓN DE CONSENTIMIENTO INFORMADO  
PARA  
TOMAR MEDICAMENTOS PSICOTRÓPICOS  
Página 1 de 2**

**Cliente:** \_\_\_\_\_

**# caso:** \_\_\_\_\_

**Programa:** \_\_\_\_\_

**Consentimiento del cliente**

**Con base en la información que leí, platiqué y/o analicé con mi personal médico:**

(Marcar una)

- Yo entiendo y doy consentimiento para toma el(los) medicamento(s) psicotrópicos de la página uno.
- Yo solo doy consentimiento verbal; me niego a firmar el formulario.
- Yo no doy consentimiento para tomar el(los) medicamento(s) psicotrópicos enumerados arriba.

Enumerarlos por favor: \_\_\_\_\_

\_\_\_\_\_  
Cliente/Rep. Legal/Firma del Tutor

\_\_\_\_\_  
Fecha

**Declaración del personal médico**

**Yo he revisado, platicado y recomendado el plan de medicamentos (página 1) para el cliente anterior y:**

- El cliente da su consentimiento para tomar estos medicamentos.
- El cliente da su consentimiento verbal pero está renuente o incapaz de firmar.
- Emergencia. Se le dio medicamento al cliente sin su consentimiento.
- El cliente no es capaz de entender los riesgos y beneficios, y por lo tanto no puedo dar su consentimiento.
- Otros comentarios:

\_\_\_\_\_  
Firma y licencia del personal médico

\_\_\_\_\_  
Fecha

\_\_\_\_\_  
Nombre impreso y licencia del personal médico

\_\_\_\_\_  
Firma del testigo (si corresponde):

\_\_\_\_\_  
Fecha

Condado de San Diego

**DECLARACIÓN DE CONSENTIMIENTO INFORMADO  
PARA  
TOMAR MEDICAMENTOS PSICOTRÓPICOS  
Página 1 de 2**

**Cliente:** \_\_\_\_\_

**# caso:** \_\_\_\_\_

**Programa:** \_\_\_\_\_

# MAY KABATIRANG PAHINTULOT SA PAGKUKUHA NG PSYCHOTROPIC NA MEDIKASYON

## ANG MGA KARAPATAN NG KLIYENTE

- Kayo ay may karapatan na magkaroon ng kaalaman tungkol sa inyong pangangalaga at magtanong.
  - Kayo ay may karapatan na tumanggap o tanggihan ang anumang o ang inyong buong plano ng pangangalaga.
  - Kayo ay may karapatan na tapusin ang inyong pahintulot sa pamamagitan ng pagsasalita o sa pamamagitan ng isang kasulatan sa sinumang miyembro ng pangkat sa anumang oras.
  - Mayroon kang karapatan para sa mga serbisyo ng wika/interpreting. *May mga hiniling na Serbisyo?* OO WALA
  - Mayroon kayong karapatan na makakuha ng kopya ng Pahintulot na ito: *Humiling ng Kopya?* OO WALA
- Emerhensyang Paggagamot** (Ang isang emerhensya ay tumutukoy sa isang pansamantala at biglaan na minarkahang pagbabago ng kinakailangan ng kilos upang maligtas ang isang buhay o maiwasan ang malubhang pinsala sa katawan ng kliyente o ng ibang tao): Sa ilang mga emerhensya, maaaring ibigay ang medikasyon sa inyo kapag hindi posibleng makuha ang inyong pahintulot. Gayunman, sa sandaling lumipas na ang emerhensya, kailangan ang inyong may kabatirang pahintulot.

### Tatalakayin sa inyo ng medikal na staff ang impormasyong nakasaad sa ibaba:

1. Kalikasan at kalubhaan ng inyong karamdamang pangkaisipan
2. (Mga) dahilan para sa (mga) gamot kasama ang posibilidad ng pagpapahusay, o hindi pagpapahusay gamit o hindi gamit ang (mga) medikasyon
3. Makatuwirang alternatibong mga paggagamot at kung bakit inirerekumenda ng doktor ang partikular na paggagamot na ito. Alternatibong dokumento, kung naaangkop:
4. Uri ng medikasyon, dosis, kadalasan ng pagkuha, tagal at paraan ng pagkuha ng (mga) medikasyon
5. Mga karaniwang kilalang side effect na maaaring maranasan ninyo: pagkabalisa nanlalabong paningin  
nahihirapan dumumi/pagtatae nanunuyong bibig nahihirapan huminga
6. Mga posibleng karagdagang side effect na maaaring mangyari kapag ginagamit ang (mga) medikasyon ng mas matagal sa tatlong buwan
7. Kung gumagamit ng tipikal o di tipikal na anti-psychotic na medikasyon, kayo ay bibigyan ng impormasyon tungkol sa isang posibleng side effect na tinatawag na **tardive dyskinesia**. Ito ay nauuri ng di kusang paggalaw ng mukha, bibig at/o mga kamay at paa. Ang mga sintomas na ito ay posibleng hindi na mababalik sa dating kalagayan at maaaring makita muli pagkatapos na ihinto ang paggamit ng medikasyon.

Naipaliwanag ang impormasyon sa lahat sa kliyente? OO HINDI Kung hindi, isadokumento ang dahilan.

### Ang medikal na staff ay nagre-reseta ng mga sumusunod na psychotropic na (mga) medikasyon para sa inyo:

Medikasyon (pangalan)	Saklaw na Dosis (gaano karami)	Kadalasan (gaano kadalasan)	Tagal (gaano katagal)	Oral (pinapadaan sa bibig) o Iniksyon (ng isang medikal na staff)
				<input type="checkbox"/> Oral <input type="checkbox"/> Iniksyon
				<input type="checkbox"/> Oral <input type="checkbox"/> Iniksyon
				<input type="checkbox"/> Oral <input type="checkbox"/> Iniksyon
				<input type="checkbox"/> Oral <input type="checkbox"/> Iniksyon
				<input type="checkbox"/> Oral <input type="checkbox"/> Iniksyon

Ang medikal na dokumento na naglalaman ng impormasyon ay binigay sa lahat ng mga psychotropic na medikasyon?

OO HINDI

**Kung hindi, ipahayag ang dahilan:**

County of San Diego

**MAY KABATIRANG PAHINTULOT SA PAGKUKUHA  
NG PSYCHOTROPIC NA MEDIKASYON**

**Pahina 1 ng 2**

**Kliyente:** \_\_\_\_\_

**Num. ng Kaso:** \_\_\_\_\_

**Programang:** \_\_\_\_\_

**Pahintulot ng Kliyente**

**Batay sa impormasyong aking natanggap, natalakay at/o napag-aralan kasama ng aking medikal na staff:**  
(plagyan ng tsek ang isa)

Aking nauunawaan at nagbibigay pahintulot ako na gumamit ng (mga) psychotropic na medikasyon na nasa unang pahina.

Ako ay nagbibigay lang ng binibigkas na pahintulot; tumangging lumagda sa form.

**Hindi** ako nagbibigay pahintulot na gumamit ng psychotropic na (mga) medikasyon na nakalista sa ibaba.

Mangyari lang ilista: \_\_\_\_\_

\_\_\_\_\_  
Lagda ng Kliyente/Legal na Kinatawan/Tagapag-alaga

\_\_\_\_\_  
Petsa

**Pahayag ng Medikal na Staff**

**Aking napag-aralan, natalakay at inirerekumenda ang plano ng medikasyon (nasa pahina 1) para sa kliyenteng nabanggit sa itaas at:**

Ang kliyente ay nagbibigay pahintulot na gamitin ang mga medikasyon na ito.

Ang kliyente ay nagbibigay ng binibigkas na pahintulot, ngunit ayaw o hindi magawang lumagda.

Emerhensiya. Ang kliyente ay nagbigay ng medikasyon ng walang pahintulot.

Hindi magawa ng kliyente na maunawaan ang mga panganib at benepisyo, at samakatuwid ay hindi makapagbigay ng pahintulot.

Iba pang mga komento:

\_\_\_\_\_  
Lagda at Lisensya ng Medikal na Staff

\_\_\_\_\_  
Petsa

\_\_\_\_\_  
Naka-print na Pangalan at Lisensya ng Medikal na Staff

\_\_\_\_\_  
Lagda ng Saksi (kung naaangkop):

\_\_\_\_\_  
Petsa

County of San Diego

**Kliyente:** \_\_\_\_\_

**MAY KABATIRANG PAHINTULOT SA PAGKUKUHA  
NG PSYCHOTROPIC NA MEDIKASYON**

**Num. ng Kaso:** \_\_\_\_\_

**Pahina 1 ng 2**

**Programa:** \_\_\_\_\_

## THỎA THUẬN SAU KHI HIỂU RÕ VỀ VIỆC DÙNG THUỐC TÁC ĐỘNG TÂM THẦN

### CÁC QUYỀN CỦA THÂN CHỦ

- Quý vị có quyền được thông báo về cách chăm sóc của mình và nêu thắc mắc.
- Quý vị có quyền chấp nhận hoặc từ khước một phần hay toàn thể chương trình chăm sóc của mình.
- Quý vị có quyền chấm dứt thỏa thuận của mình bằng lời nói hoặc bằng cách viết thư cho bất cứ một thành viên nào của nhóm vào bất cứ lúc nào.
- Quý vị có quyền hưởng các dịch vụ về ngôn ngữ/thông dịch. *Yêu Cầu Dịch Vụ?* CÓ KHÔNG
- Quý vị có quyền được một bản sao của Thỏa Thuận này: *Yêu Cầu Một Bản Sao?* CÓ KHÔNG

**Chữa Trị Cấp Cứu** (*Cấp cứu là một sự thay đổi tạm thời, đột ngột rõ rệt đòi hỏi phải hành động để bảo tồn sự sống hoặc ngăn chặn thiệt hại nghiêm trọng đối với thân thể của thân chủ hoặc những người khác*): Trong một số tình trạng cấp cứu, thuốc có thể được dùng cho quý vị khi không thể có sự thỏa thuận của quý vị. Tuy nhiên, sau khi tình trạng cấp cứu đã qua, thì cần phải có sự thỏa thuận của quý vị.

#### Nhân viên y tế sẽ bàn luận với quý vị về những chi tiết dưới đây:

1. Bản chất và tính cách nghiêm trọng của chứng bệnh tâm thần của quý vị
2. (Những) lý do sử dụng (những) thuốc này bao gồm cả khả năng có thể thuyên giảm hoặc không thuyên giảm khi dùng hoặc không dùng (những) thuốc này
3. Những cách chữa trị hợp lý khác và tại sao bác sĩ đề nghị cách chữa trị đặc biệt này. Cung cấp tư liệu về cách chữa trị khác, nếu thích hợp:
4. Loại, liều lượng, mức thường xuyên, khoảng thời gian dùng, và phương thức dùng (những) thuốc này
5. Những tác dụng phụ được biết thường xảy ra mà quý vị có thể bị: khích động mất mờ  
táo bón/tiêu chảy miệng khô khó thở
6. Những tác dụng phụ khác có thể xảy ra khi dùng (những) thuốc này lâu hơn ba tháng
7. Nếu dùng một loại thuốc giảm rối loạn thần kinh đúng kiểu hay không đúng kiểu, quý vị sẽ được thông báo chi tiết về một tác dụng phụ có thể xảy ra được gọi là **tardive dyskinesia (rối loạn vận động muộn)**. Tác dụng phụ này được biểu hiện bằng đặc điểm là những chuyển động của mặt, miệng và/hoặc tay và chân. Những triệu chứng này có thể sẽ không thay đổi được và có thể xuất hiện sau khi ngưng dùng thuốc.

Các chi tiết trên có được giải thích cho thân chủ không? CÓ KHÔNG Nếu không, ghi rõ lý do để làm tư liệu.

#### Nhân viên y tế kê toa (những) thuốc tác động tâm thần sau đây cho quý vị:

Thuốc (tên)	Tầm Mức Liều Lượng (bao nhiêu)	Mức thường xuyên (thường xuyên như thế nào)	Thời Gian Sử Dụng (bao lâu)	Miệng (bằng miệng) hoặc Tiêm (bởi nhân viên y tế)
				<input type="checkbox"/> Miệng <input type="checkbox"/> Tiêm
				<input type="checkbox"/> Miệng <input type="checkbox"/> Tiêm
				<input type="checkbox"/> Miệng <input type="checkbox"/> Tiêm
				<input type="checkbox"/> Miệng <input type="checkbox"/> Tiêm
				<input type="checkbox"/> Miệng <input type="checkbox"/> Tiêm

Có bản ghi chi tiết về thuốc được cung cấp cho tất cả các loại thuốc tác động tâm thần? CÓ KHÔNG  
Nếu không, ghi rõ lý do để làm tư liệu.

Quận San Diego

**THỎA THUẬN SAU KHI HIỂU RÕ VIỆC DÙNG THUỐC TÁC ĐỘNG TÂM THẦN**  
Trang 1 trên 2

**Thân Chủ:** \_\_\_\_\_

**Vụ Việc #:** \_\_\_\_\_

**Chương Trình:** \_\_\_\_\_

**Thỏa Thuận của Thân Chủ**

**Dựa vào những chi tiết tôi đã đọc, bàn luận và/hoặc xem xét với nhân viên y tế của tôi:**  
(đánh dấu một)

- Tôi hiểu và thỏa thuận dùng (những) thuốc tác động tâm thần trên trang một.
- Tôi chỉ thỏa thuận bằng lời nói; không ký tên trên mẫu đơn.
- Tôi **không** thỏa thuận dùng (những) thuốc tác động tâm thần được liệt kê dưới đây.

Xin vui lòng liệt kê:

\_\_\_\_\_

\_\_\_\_\_  
Chữ Ký của Thân Chủ/Đại Diện Pháp Lý/Người Giám Hộ

\_\_\_\_\_  
Ngày

**Tuyên Ngôn của Nhân Viên Y Tế**

**Tôi đã xem xét, bàn luận và đề nghị chương trình dùng thuốc (trang 1) cho thân chủ ở trên và:**

- Thân chủ thỏa thuận dùng những thuốc này.
- Thân chủ thỏa thuận bằng lời nói, nhưng không muốn hoặc không thể ký tên.
- Tình trạng cấp cứu. Thân chủ được cho dùng thuốc mà không có sự thỏa thuận.
- Thân chủ không thể hiểu được những nguy cơ và lợi ích, và do đó không thể thỏa thuận.
- Những Nhận Xét Khác:

\_\_\_\_\_  
Chữ Ký và Giấy Phép của Nhân Viên Y Tế

\_\_\_\_\_  
Ngày

\_\_\_\_\_  
Tên Được Viết Theo Kiểu Chữ In và Giấy Phép của Nhân Viên Y Tế

\_\_\_\_\_  
Chữ Ký của Nhân Chứng (nếu thích hợp):

\_\_\_\_\_  
Ngày

Quận San Diego

**THỎA THUẬN SAU KHI HIỂU RÕ VIỆC DÙNG  
THUỐC TÁC ĐỘNG TÂM THẦN  
Trang 1 trên 2**

**Thân Chủ:** \_\_\_\_\_

**Vụ Việc #:** \_\_\_\_\_

**Chương Trình:** \_\_\_\_\_

## **COMPLETED BY:**

1. Physician (MD or DO)
2. Nurse Practitioner
  - a. **\*\*Note: While the forms state “Medical Staff” for signature being obtained this still only applies to a Physician or Nurse Practitioner.\*\***

## **COMPLIANCE REQUIREMENTS:**

1. Required for all client receiving psychotropic medication.
2. Updated when there is a medication change.
3. Client and/or Parent Guardian must sign and date.
4. All areas and fields shall be addressed and staff completing must sign and date.

## **DOCUMENTATION STANDARDS:**

1. State law defines informed consent as the voluntary consent of the client to take psychotropic medication after the physician has reviewed the following with him/her:
  - a. Explanation of the nature of the mental problem and why psychotropic medication is being recommended.
  - b. The general type (antipsychotic, antidepressant, etc.) of medication being prescribed and the medication's specific name.
  - c. The dose, frequency and administration route of the medication being prescribed.
  - d. What situations, if any, warrant taking additional medications.
  - e. How long it is expected that the client will be taking the medication.
  - f. Whether there are reasonable treatment alternatives.
  - g. Documentation of "informed consent" to take psychotropic medication. A new form is to be completed:
    - i. When a new or different type of medication is prescribed.
    - ii. When the client resumes taking medication following a documented withdrawal of consent.



**REQUEST FOR ACCESS AND/OR COPY OF PROTECTED  
HEALTH INFORMATION  
(County Providers)**



**COMPLETED BY:**

1. Client and/or guardian

**COMPLIANCE REQUIREMENTS:**

1. **\*\*This is a county form (23-01 HHSA 04/03) for county providers. Contracted providers are to seek their own legal counsel. \*\***
2. All areas and fields shall be addressed.
3. Signature and date of client and/or legal guardian submitting request.
4. Staff member processing the request shall sign and date form as well as complete T Bar information to include the client's name, Case number, and program name.

**DOCUMENTATION STANDARDS:**

1. Clients who are 18 years of age or older or emancipated may submit their own request.
2. Additionally, under some circumstances a minor 12 years and older may submit their own request (see Welfare and Institutions Code 14010 and Family Code 6924, 6929, 7050).
3. Day Programs provide an all-inclusive rate and shall capture the billing of all clients enrolled in their program on a given day utilizing their own program's billing record.

**COUNTY OF SAN DIEGO**

**REQUEST FOR ACCESS AND/OR COPY OF PROTECTED HEALTH INFORMATION**

You have the right to request to review your personal health information we create or maintain. You also have the right to request copies of those records for which you will be charged \$.15 per page. Within five (5) business days after we receive your request to access your record, one of our staff will contact you to set an appointment for you to review your records or we will inform you in writing that we have denied your request for access and state the reason why. After you have completed this form, you need to mail or return it to:

**SAN DIEGO COUNTY MENTAL HEALTH  
P.O. BOX 85524  
SAN DIEGO, CA 92186-5524  
(619) 692-5700 EXT 3**

DATE:
-------

PATIENT/RESIDENT/CLIENT		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS	CITY/STATE:	ZIP CODE:
AKA'S		
TELEPHONE NUMBER:	SSN:	DATE OF BIRTH:

---

<b>County of San Diego</b>	Client: _____
<b>REQUEST FOR ACCESS AND/OR COPY OF PROTECTED HEALTH INFORMATION</b>	Record Number: _____
	Program: _____

**REPRESENTATIVE INFORMATION**  
**(Complete only if you want us to give your information to another person or entity.)**

I authorize the following person to receive the requested information.

LAST NAME OR ENTITY:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS	CITY/STATE:	ZIP CODE:
RELATIONSHIP:		TELEPHONE NUMBER:

**PERSONAL HEALTH INFORMATION TO WHICH YOU WANT ACCESS**

- |  |  |
|--|--|
| <input type="checkbox"/> History and Physical Examination<br><input type="checkbox"/> Discharge Summary<br><input type="checkbox"/> Progress Notes<br><input type="checkbox"/> Medication Records<br><input type="checkbox"/> Interpretation of images: x-rays, sonograms, etc.<br><input type="checkbox"/> Laboratory results<br><input type="checkbox"/> Dental records<br><input type="checkbox"/> Psychiatric records including Consultations<br><input type="checkbox"/> HIV/AIDS blood test results; any/all references to those results | <input type="checkbox"/> Physician Orders<br><input type="checkbox"/> Pharmacy records<br><input type="checkbox"/> Immunization Records<br><input type="checkbox"/> Nursing Notes<br><input type="checkbox"/> Billing records<br><input type="checkbox"/> Drug/Alcohol Rehabilitation Records<br><input type="checkbox"/> Complete Record<br><input type="checkbox"/> Other ( <i>Provide description</i> ) _____<br>_____<br>_____ |
|--|--|

**From what dates do you want information (*period of time*)**

Date to begin search:	Date to end search:
-----------------------	---------------------

**County of San Diego**

**REQUEST FOR ACCESS AND/OR COPY OF PROTECTED HEALTH INFORMATION**

**Client:** \_\_\_\_\_

**Record Number:** \_\_\_\_\_

**Program:** \_\_\_\_\_

ACCESS METHOD AND LOCATION

Where and when do you want to inspect or receive copies of your information:

IN PERSON:

YES

LOCATION:

COPIES BY MAIL:

YES

YOUR SIGNATURE

SIGNATURE:

DATE:

FOR OFFICE USE

VALIDATION

SIGNATURE OF STAFF PERSON VALIDATING INFORMATION:

DATE:

SIGNATURE OF HEALTH CARE PROVIDER\*:

DATE:

County of San Diego

REQUEST FOR ACCESS AND/OR COPY OF  
PROTECTED HEALTH INFORMATION

Client: \_\_\_\_\_

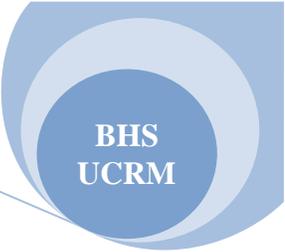
Record Number: \_\_\_\_\_

Program: \_\_\_\_\_

# PATHWAYS TO WELL- BEING

## Section 8

# PATHWAYS TO WELL-BEING INDIVIDUAL PROGRESS NOTE/ ICC NOTE

The logo for BHS UCRM is located in the top right corner. It consists of three concentric circles in shades of blue, with the text "BHS" above "UCRM" in white, centered within the innermost circle.

BHS  
UCRM

## **COMPLETED BY:**

1. Staff delivering services within scope of practice. Co-signatures must be completed within timelines.

## **COMPLIANCE REQUIREMENTS:**

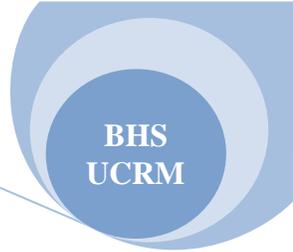
1. The ICC Progress note will be used to document any ICC service, including Child and Family Team (CFT) Meetings.
2. Completed for those clients identified as Pathways to Well-Being Enhances, as well as those clients that require more intensive services.
3. Notes must be completed and final approved, or signed, within 14 days from day of service.

## **DOCUMENTATION STANDARDS:**

1. Programs should refer to the ICC Note Template and complete all areas and fields that apply.
2. If using the template for a CFT Meeting, be sure to complete the second half of the note as well.
3. Multiple members of the CFT Meeting may bill for their role in the meeting.
4. Safety, permanency, and well-being are the motivation behind ICC services. Documentation should reflect these goals.



**ELIGIBILITY FOR PATHWAYS TO WELL-BEING  
AND ENHANCED SERVICES  
(Katie A.- Class or Sub-Class)**



**COMPLETED BY:**

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
5. Registered Nurse

**COMPLIANCE REQUIREMENTS:**

1. The Pathways to Well-Being Eligibility Form must be completed:
  - a. Intake
  - b. Discharge
  - c. When open or closed to Child Welfare Services
  - d. During any other noted changes throughout treatment
2. The form is completed for all clients open to the Children's SOC.
3. If client is open to Child Welfare Services:
  - a. A Progress Report to Child Welfare Services must be completed within 30 days and securely sent to CWS Protective Services Worker.

**DOCUMENTATION STANDARDS:**

1. All areas and fields shall be completed.
2. Billing for gathering of information for the Pathways to Well-Being Eligibility form shall only occur when it is connected to a direct client service.
3. To determine if there has been a petition filed or if it is a voluntary services case and who the CWS Protective Services Worker is, contact CWS at (858) 694-5191
4. Form fill or hand written and maintain a copy in the medical record Class or Enhanced Services (Sub-Class) level must be identified in the Electronic Health Record.

# Eligibility for Pathways to Well-Being & Enhanced Services

(Katie A. – Class or Sub-Class)

Intake    Reassessment    Discharge

Eligibility is assessed at intake & discharge & if indicated during the course of treatment. If upon discharge client continue to meet Enhanced Services/Sub-Class level, current provider must connect client to a Pathways – Enhanced Services/Sub-Class provider who can offer Care Coordination and ICC. Identifying/updating Class (Open to CWS) vs. Sub-Class (Enhanced Services) level in Anasazi is critical.

**Child/youth meets criteria for Enhanced Services (Katie A. Sub-Class) if:**

- Answers to item 1, 2, and 3 below are all 'yes' **AND**
- Answer to item 4 **OR** 5 is 'yes'

- |  |  |                              |                             |
|--|--|------------------------------|-----------------------------|
| 1. Child/youth has open <u>Child Welfare Services Case</u> (petition filed or voluntary services)?   |  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Child/youth meets <u>Medical Necessity</u> criteria (included diagnosis; significant impairment in an important area of life functioning; and intervention will result in positive impact)? |  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Child/youth (up to age 21) has <u>full scope Medi-Cal</u> ?   |  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Child/youth has had <u>3 or more placements within 24 months</u> due to behavioral health needs?  |  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Child/youth currently <u>receiving or being considered for any of the following services:</u>   |  |                              |                             |
| Crisis Stabilization (ESU)   |  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Placement in a RCL 10 or above facility  |  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Placement in psychiatric hospital or 24 hour mental health treatment facility (ex. PHF)  |  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Special Care Rate (SCR) due to behavioral health needs   |  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Therapeutic Behavioral Services (TBS)  |  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Wraparound, Comprehensive Assessment and Stabilization Services (CASS),<br>Foster Family Agency Stabilization and Treatment (FFAST) Program  |  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Intensive Treatment Foster Care (ITFC), Multidimensional Treatment Foster Care (MTFC)  |  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Clients who are eligible for Enhanced Services (members of the Sub-Class) **must** have a Care Coordinator as well as receive Intensive Care Coordination (ICC) & a formal Child and Family Team (CFT). ICC is provided but may not be billable in lockout situations. In-Home Based Services (IHBS) shall be offered as clinically indicated to Enhanced Services/Sub-Class members.

**Eligible for Enhanced Services (Sub-Class)**    Yes    No

**Not eligible for Enhanced Services (Sub-Class); but is eligible for Pathway (class)**

- Client will be identified as Class in Anasazi and will receive informal child/family teaming and support with CWS taking the lead.

**Not eligible for Enhanced Services (Sub-Class) and not eligible for Pathway (class)**

- If Anasazi currently reflects active to class or sub-class; both need to be de-activated.

Checklist of items for completion:	Date
Name of Child Welfare Services SW (call 858-694-5191 to obtain current worker):	
Switch flipped on in Anasazi and progress note completed to reflect Sub-Class/Class eligibility status on:	
If Enhanced Services (Sub-Class member), Client Plan was updated to incorporate safety and permanency goals/objectives on:	
If Enhanced Services (Sub-Class member), Client Plan was updated to include ICC, CFT, and IHBS as applicable on:	
Informed case was closed to Child Welfare Services (if applicable) on:	
Client changed categories or was de-activated to Pathways services (if applicable) on:	
Care Coordinator:	Program Name:
Completed By (Printed Name):	Credential:
Signature:	Date:

Note: Complete and provide to CWS the Pathways to Well-Being Progress Report to Child Welfare Services form at intake, quarterly and upon discharge.

County of San Diego  
Health and Human Services Agency  
Child Welfare Services  
Behavioral Health Services

**PATHWAYS TO WELL-BEING / ENHANCED SERVICES ELIGIBILITY**  
**KATIE A. (CLASS / SUB-CLASS)**  
Page 1 of 1

**Client:** \_\_\_\_\_

**D.O.B.:** \_\_\_\_\_

**Record Number:** \_\_\_\_\_

**Program:** \_\_\_\_\_

# PROGRESS REPORT TO CHILD WELFARE SERVICES PATHWAYS TO WELL-BEING

BHS  
UCRM

**COMPLETED BY:**

1. Licensed/Waivered Psychologist
2. Licensed/Registered/Waivered Social Worker or Marriage and Family Therapist
3. Licensed/Registered Professional Clinical Counselor
4. Physician (MD or DO)
- 5.

**WHEN:**

The Progress Report to Child Welfare Services (CWS) form must be completed at intake, quarterly, at discharge, and when any significant changes occur. The initial report is to be submitted within 30 days of Open to CWS (Class) or Enhanced Services (Sub-Class) identification.

**ON WHOM:**

All clients identified within Pathways to Well-Being as Open to CWS (Class) or Enhanced Services (Sub-Class) must have a completed Progress Report to Child Welfare Services

**COMPLETED BY:**

Reviewing clinical service provider (i.e. Care Coordinator, Therapist)  
Must be completed by provider eligible to determine medical necessity:

Registered Nurse

**MODE OF  
COMPLETION:**

Form fill or hand written and forwarded in a secure manner to CWS Protective Services Worker and maintain a copy in the medical record

**REQUIRED  
ELEMENTS:**

All elements of the Progress Report to Child Welfare Services must be addressed including:

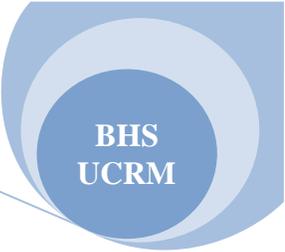
- Identification of Open to CWS (Class) or Enhanced Services Eligible (Sub-Class)
- Name of Care Coordinator
- Date of next Child and Family Team (CFT) Meeting
- Identification of what is needed from CWS, including secure contact to receive information
- DSM diagnosis

Attachment of the following documents:

If identified as Eligible for Enhanced Services (Sub-Class):

- Client Plan
- CAMS results
- CFARS

# PROGRESS REPORT TO CHILD WELFARE SERVICES PATHWAYS TO WELL-BEING

The logo for BHS UCRM is located in the top right corner. It consists of three overlapping circles in shades of blue, with the text "BHS" above "UCRM" in white, centered within the innermost circle.

BHS  
UCRM

- Client Assignment History
- CFT meeting note (when sending as a quarterly report)
- Discharge Summary, if at discharge

If identified as Class:

- Only Client Plan must be attached

## **BILLING:**

Billing for gathering of information for the Progress Report to Child Welfare Services shall only occur when it is connected to a direct client service

# Progress Report to Child Welfare Services

## Pathways to Well-Being

Initial (within 30 days of Enhanced Services (Sub-Class) or Open to CWS (Class) identification)     Quarterly     Discharge

**Report Period From:                      To:**

Child Welfare Services (CWS) Worker Name:

CWS Worker Phone Number:

CWS Worker Secure Fax:

Provider may call 858-694-5191 to obtain name and contact information of current Child Welfare Services worker.

Youth meets <u>Enhanced Services (Sub-Class)</u> criteria: <input type="checkbox"/> yes <input type="checkbox"/> no Comments:	<input type="checkbox"/> Youth <u>only</u> meets <u>Open to CWS (Class)</u> criteria ( <b><i>not</i></b> Enhanced Services (Sub-Class)): Record in Anasazi and provide CWS SW with this form & Client Plan
---	---

<p style="text-align: center;"><b>**BEHAVIORAL HEALTH PROVIDERS**</b></p> <p><b>Please provide the following items to CWS worker</b> (provide all relevant and updated materials):</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Current Client Plan</li> <li><input type="checkbox"/> CFT Progress Summary and Action Plan (most recent)</li> <li><input type="checkbox"/> Current completed CAMS questionnaire</li> <li><input type="checkbox"/> Current CFARS evaluation</li> <li><input type="checkbox"/> Current Client Assignment history from Anasazi</li> <li><input type="checkbox"/> Discharge Summary</li> <li><input type="checkbox"/> Other:</li> </ul> <p>Provider Name:                  Title:                  Phone Number:                  Secure Fax:                  Next Child and Family Team Meeting Date:                  Comments:</p>	<p style="text-align: center;"><b>**CWS WORKERS **</b></p> <p><b>Upon receipt of items from Behavioral Health providers/Care Coordinator, please provide the following items to Behavioral Health Provider</b> (provide all relevant and updated materials to secure fax number listed in left column):</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blanket Court Order (Order Authorizing Health Assessments, Routine Health Care, &amp; Release of Information)</li> <li><input type="checkbox"/> 04-24 Consent for Examination and Treatment</li> <li><input type="checkbox"/> CFT Progress Summary and Action Plan (from previous provider, if applicable)</li> <li><input type="checkbox"/> Child Welfare Services Case Plan</li> <li><input type="checkbox"/> Detention Report</li> <li><input type="checkbox"/> Jurisdictional/Disposition Report</li> <li><input type="checkbox"/> Status Review Court Reports (every 6 months):</li> <li><input type="checkbox"/> No Contact List (if applicable)</li> <li><input type="checkbox"/> Health and Education Passport (HEP)</li> <li><input type="checkbox"/> Other:</li> </ul>
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**CWS workers are NOT to attach this document to court reports**

Diagnostic Impression:	DSM Code	Diagnosis
Axis I <b>Primary</b>		
<b>Secondary</b>		
Axis II		
Axis III		
Axis IV (identified stressors)		
Axis V (GAF)	<b>Current:</b>	<b>Highest past year, if known:</b>

Provider's Name:                      Signature: \_\_\_\_\_     Licensed                      Credentials:                      Date:

County of San Diego  
 Health and Human Services Agency  
 Child Welfare Services  
 Behavioral Health Services

**PATHWAYS TO WELL-BEING  
 PROGRESS REPORT TO CHILD WELFARE SERVICES 5-1-15 FINAL**

Client: \_\_\_\_\_  
 Record Number: \_\_\_\_\_  
 Program: \_\_\_\_\_

**PATHWAYS TO WELL-BEING  
CHILD & FAMILY TEAM MEETING  
PROGRESS SUMMARY AND ACTION PLAN  
(CWS FORM 04-174)**

**COMPLETED BY:**

1. Any professional member of the Child & Family Team may complete the Progress Summary and Action Plan.

**COMPLIANCE REQUIREMENTS:**

1. Shall be completed at every CFT Meeting, with a new form being completed each time the team meets.
2. Shall be completed for all clients that have a CFT Meeting.
3. All fields and areas shall be addressed.
4. All CFT Members shall sign the last page of the Meeting Summary.

**DOCUMENTATION STANDARDS:**

1. Billing for gathering of information for the CFT Meeting Progress Summary and Action Plan shall only occur when it is connected to a direct client service.
2. This form is a tool for the Child and Family Team and is completed in collaboration with Child Welfare Services.
3. A professional member shall be identified to complete the form at each CFT meeting.
4. Document may be kept in the back of the medical record.
5. A copy shall be given to all CFT members after the meeting.

**Pathways to Well-Being  
Child and Family Team (CFT) Meeting  
PROGRESS SUMMARY and ACTION PLAN**

<p><b><u>Meeting Date:</u></b></p> <p><b><u>Facilitator:</u></b></p> <p><b><u>Check one:</u></b>  <input type="checkbox"/> Initial Meeting  <input type="checkbox"/> Follow Up Meeting</p>	<p><b><u>Mother(s) Name:</u></b></p> <p><b><u>Father(s) Name:</u></b></p> <p><b><u>Caregiver Name:</u></b></p>	<p><b><u>Child/Youth's Name:</u></b></p> <p><b><u>DOB:</u></b></p> <p><b>Intensive Care Coordination (check one):</b>  <input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Not Yet Determined</p>
--	--	---

**Identified Goal for Meeting:** \_\_\_\_\_

Existing Support/Services	Continue ?	Additions to Support/Services Recommended by team
	Y <input type="checkbox"/> N <input type="checkbox"/>	
	Y <input type="checkbox"/> N <input type="checkbox"/>	
	Y <input type="checkbox"/> N <input type="checkbox"/>	
	Y <input type="checkbox"/> N <input type="checkbox"/>	

What needs to happen?	Who is going to make it happen?	When will it be completed?
		Completed on:

**Next meeting date (AS NEEDED, and no more than 90 days if youth is receiving ICC) and/or communication plan:**

\_\_\_\_\_



**PATHWAYS TO WELL-BEING  
CHILD & FAMILY TEAMING STANDARDS  
(CWS FORM 04-173)**

**COMPLETED BY:**

1. Any professional member of the Child & Family Team may complete.

**COMPLIANCE REQUIREMENTS:**

1. The Child & Family Teaming Standards is to be reviewed at the initial Child and Family Team (CFT) meeting.
2. The following elements of the Child & Family Teaming Standards are to be completed:
  - a. List of Team Members
  - b. Group Agreements, created and agreed upon by team
3. The form should be given to new members as they join the team and reviewed periodically.
4. Shall be completed for all clients that have CFT Meetings.

**DOCUMENTATION STANDARDS:**

1. The following elements of the Child & Family Teaming Standards should be reviewed with the team by the meeting facilitator:
  - a. The Team Foundation
  - b. Team Practices
  - c. Maintaining the Pathway
  - d. Principles of Family Youth Professional Partnership
2. Billing for gathering of information and review of the Child & Family Teaming Standards shall only occur when it is connected to a direct client service.
3. Document may be kept in the back of the medical record.
4. A copy shall be given to all CFT members at the initial meeting.
5. This form is a tool for the Child and Family Team and is completed in collaboration with Child Welfare Services.

## Pathways to Well-Being Child and Family Teaming Standards

### The Team Foundation

Pathways to Well-Being is about changing the way Child Welfare Services (CWS) and Behavioral Health Services (BHS) work with **children, youth and their families**. Central to this change will be Child and Family Teams (CFTs). CFTs are *family, youth, professional partners, and natural supports working together, by sharing information, resources, and responsibilities. Team members are responsive to the needs, values, and success of each partner. The team works with genuine intent to achieve the team's common purpose.*

This document is intended as a standards guide to assist Child and Family Teams in their work together. It will be given to each team member. A review of these standards with the team at their first meeting and throughout the teams' lifespan will ensure team equity and guide the way the CFT works together.

### Our Child and Family Team (Members in **bold** are required participants)

Team Member	Name and Phone Number	Expertise/Strength
<b>Child/Youth</b>		
<b>Birth Family</b>		
<b>Current Caregiver</b>		
<b>CWS worker</b>		
<b>BHS provider</b>		
Permanent Community Connection		
Natural Supports:		

## Group Agreements

**Strive to adhere to the Principles of Family Youth Professional Partnership (refer to page 3)**

### Team Practices

*“Coming together is a beginning,  
keeping together is progress,  
working together is success.”  
- Henry Ford*

✓ <b>Formal Meeting Schedule</b>	First meeting will take place within 30-days of establishing eligibility for enhanced services, and at a minimum of every 90 days for children/youth thereafter. Meetings shall be short, focused, and no longer than 1.5 hours.
✓ <b>Meeting Structure</b>	The meeting structure will include: Introduction, Identifying the Situation, Assessing the Situation, Developing Ideas, Reaching a Decision, and Evaluating the Meeting.
✓ <b>Communication</b>	<i>Not about me without me!</i> All communications (formal and informal) regarding child and/or family will be disclosed to all team members.
✓ <b>Selection of Additional Team Members</b>	The team creates a process for inviting additional team member(s)
✓ <b>Action Items</b>	<p>Action items are:</p> <ul style="list-style-type: none"> <li>• Agreed to by the team or the facilitator will document team members that disagree and reasoning behind their disagreement</li> <li>• Assigned based on each member’s strength and/or expertise</li> <li>• Supported by each member in order to accomplish the agreed upon actions</li> <li>• Routinely evaluated by the team for potential changes to adapt to the mission, goals, and objectives of the youth, family, and team.</li> </ul>

### Maintaining the Pathway

*“Success is not final.*

*failure is not fatal,  
it is the courage to continue that counts.”  
-Winston Churchill*

✓ <b>Transition Planning</b>	Transition planning begins at the onset of Teaming. The youth and family will identify their needs for successful transition to lower levels of care and exit from the Child Welfare system. The youth and family shall also receive resources and expertise from the Behavioral Health Services provider and Child Welfare Services worker to support a successful transition. Transition goals will be incorporated into the team’s meetings, goals, and action items.
✓ <b>Transition Period</b>	Transition planning shall have set timetables that are monitored to ensure actions/goals for successful transition are made and/or readjusted to meet the youths evolving needs.
✓ <b>Are we there?</b>	Transition planning goals should be incorporated into CFT meetings and goals should be evaluated to ensure action steps are completed and/or are appropriate to meet the transitional needs.

### **PRINCIPLES of Family Youth Professional Partnership**

**Family, Youth Professional Partnership (FYPP)** are family, youth and professional partners working together, by sharing information, resources, and responsibilities. Partners are responsive to the needs, cultures, and success of each partner. A successful FYPP utilizes a multi-stakeholder approach, where there is genuine intent to achieve their common purpose.

**Responsibility:** Each *Family-Youth and Professional partner* takes ownership in the partnership by committing to be responsible for the success of the partnerships’ achievements.

**Agreement:** The foundation of FYPP is a strong commitment from each partner to collaborate. This is demonstrated by full agreement on what is to be achieved. Each partner agrees to ensure the success of the partnership. Partners also commit to ownership in achievement of outcomes.

**Influence:** All decisions related to achievement of outcomes are decided on together. Decisions are family centered, not service driven, and there is full understanding of each partner’s perspective and needs before decisions are made.

**Sharing:** Each partner brings equally important knowledge and information. Partners agree that each perspective is vital to their success. Partners share their knowledge and reflect on the expertise provided to them.

**Excellence:** To achieve excellence in FYPP there needs to be formal mechanisms in place that provides for feedback at all levels. Each perspective must be considered and given equal influence in decisions that affect outcomes.