Children/Youth (ECM) Comprehensive Assessment

This assessment is a tool for you, the member's ECM Lead Care Manager, to assess a **Child/Youth** member's health needs and help the **Child/Youth** member participate in the Enhanced Care Management benefit. Today and maybe over the next 1-3 visits, you and the **Child/Youth** member will complete this assessment together, and from there, develop goals and next steps that support the

Child/Youth member's overall health and wellness.

Section 1. Population of Focus and other County Programs window

The purpose of this section is to indicate the Child/Youth member's Population of Focus and identify other programs the Child/Youth member is involved in and support you to coordinate the Child/Youth member's care and health-related social needs.

1.* Population(s) of Focus for child/youth member as identified on *MIF/TEL/Referral email/Member Activity Report* (select all that apply):

- ☐ Individuals Experiencing Homelessness
- ☐ Families Experiencing Homelessness
- ☐ At-risk for Avoidable Hospital/Emergency Department (ED) Utilization
- ☐ Serious Mental Illness (SMI)/Substance Use Disorder (SUD)
- ☐ California Children's Services (CCS)/CCS Whole Child Model (WCM)
- ☐ Child Welfare
- ☐ Transitioning from Youth Correctional Facility
- ☐ Birth Equity

2.* Programs the child/youth member is involved in (select all that apply):

- ☐ Specialty Mental Health Services (SMHS)
- ☐ Drug Medi-Cal (DMC)
- ☐ Drug Medi-Cal Organized Delivery System (DMC-ODS)
- ☐ Juvenile Justice
- ☐ California Children's Services (CCS)
- ☐ California Children's Services (CCS)/CCS Whole Child Model (WCM)
- ☐ Child Welfare
- ☐ Regional Center Services
- ☐ Local program serving pregnant/postpartum individuals (e.g., Comprehensive Perinatal Services Program [CPSP], California Home Visting Program [HVP], etc.)

- ☐ Other(s)

Question required to be completed

3.* Date of consent for Opt-In to ECM services (refer to ECM Opt-In date in you Member Activity report):

MM/DD/YYYY

4.* Type of Consent

- ☐ Verbal Consent
- ☐ Written Consent

5. * Who Consented:

- ☐ Child/Youth Member
- ☐ Parent/Guardian/Caregiver
- ☐ Department of Children and Family Services (DCFS)
- ☐ Court
- ☐ Foster Parent(s)

6.*Does Child/Youth member (or their parent/guardian/caregiver, if applicable) provide verbal agreement for data sharing related to care coordination through ECM?

- ☐ Yes
- ☐ No

7.*Is anyone else in the family enrolled in ECM?

- ☐ Yes
- ☐ No

8.* If yes, list family member name(s), relationship(s) to Child/Youth member, and ECM Provider(s)

Indicate if you used any of the following, recently completed assessments or tools to complete/inform this assessment. The ECM Lead Care Manager should incorporate findings from all available assessments. Assessment do not replace this comprehensive assessment but should inform development of the care plan.

****Question required to be completed***

9. *ACEs or PEARLS (*If no ACES or PEARLS screening completed: refer to PCP/SW for screening.)*

☐ Yes
☐ No
☐ N/A
*Date Completed: MM/DD/YYYY

10. *CANS Assessment:

☐ Yes
☐ No
☐ N/A
*Date Completed: MM/DD/YYYY

11. *PSC-35:

☐ Yes
☐ No
☐ N/A
*Date Completed: MM/DD/YYYY

12. *Needs Evaluation Tool:

☐ Yes
☐ No
☐ N/A
*Date Completed: MM/DD/YYYY

13. *Youth Screening Tool:

☐ Yes
☐ No
☐ N/A
*Date Completed: MM/DD/YYYY

Question required to be completed

14. *(DPH Foster Care) Child Health Evaluation:

☐ Yes
☐ No
☐ N/A

*Date Completed: MM/DD/YYYY

15. *Protective Factors Survey:

☐ Yes
☐ No
☐ N/A

*Date Completed: MM/DD/YYYY

16. *(DCFS) Multidisciplinary Assessment Team:

☐ Yes
☐ No
☐ N/A

*Date Completed: MM/DD/YYYY

17. *(CCS) Patient Care Assessment:

☐ Yes
☐ No
☐ N/A

*Date Completed: MM/DD/YYYY

18. *(DDS) Regional Center Assessment:

☐ Yes
☐ No
☐ N/A

*Date Completed: MM/DD/YYYY

Question required to be completed

19. *(Pregnant/Postpartum)CPSP Assessment:

☐ Yes
☐ No
☐ N/A

*Date Completed: MM/DD/YYYY

20. *(Justice Involved) Re-entry Transitional Plan:

☐ Yes
☐ No
☐ N/A

*Date Completed: MM/DD/YYYY

*Other(s) List Below along with date completed:

[1]*The Child and Adolescent Needs and Strengths Assessment is used by DCFS/Child Welfare and by SMHS/DMH*
[2]*The Pediatric Symptom Checklist is used by SMHS/DMH*
[3]*The Needs Evaluation Tool is used by DMH.*
[4]*The Youth Screening Tool is used for Medi-Cal Mental Health Services, DHCS*
[5]*The PFS is used by the Prevention and Aftercare Network, DCFS*
[6]*The Multidisciplinary Assessment Team includes their level of care tool and the Resource Family Reporting Tool, used by DMH for a child newly entering the foster care system.*

Section 2. Demographics and Child/Youth Member's Needs/Preferences

Child/Youth Member and Family Demographics

21.*Primary Point of Contact for ECM Services:

☐ Child/Youth Member
☐ Parent/Guardian/Caregiver
☐ Other (list):

Question required to be completed

22. *Person(s) you are speaking with to complete this assessment (select all that apply):

- ☐ Child/Youth Member
- ☐ Parent/Guardian/Caregiver
- ☐ Other (list):

**23. ***Date Assessment Started: MM/DD/YYYY

24. *Child/Youth Member's First Name:

25. *Child/Youth Member's Last Name:

26. *Child/Youth Member's Date of Birth:

27. *Child/Youth Member's Medicaid ID:

28. *Child/Youth Member's Preferred name and/or Pronouns:

29. *Child/Youth Member's gender identification:

Preferred written/spoken language (*What language are you most comfortable speaking and reading*?):

30. *Child/Youth Member:

31. *Parent/Guardian/Caregiver:

Question required to be completed

32. *Interpreter needed:

☐ Yes
☐ No

**Language:*

33. * Do you have any cultural, religious and/or spiritual beliefs that are important to your family's health and wellness:

☐ Yes
☐ No
☐ Decline to answer

*If Yes, describe:

34. *Relationship status of Child/Youth Member:

☐ N/A
☐ Single
☐ Married
☐ Divorced
☐ Domestic Partnership
☐ Widowed
☐ Decline to answer
☐ Other (list):

35. *Relationship status of parent/guardian/caregiver:

☐ N/A
☐ Single
☐ Married
☐ Divorced
☐ Domestic Partnership
☐ Widowed
☐ Decline to answer
☐ Other (list):

Question required to be completed

36. *Parent/Guardian/Caregiver Name:

37. *Contact Information:

38. *Child/Youth Member's Parent/Guardian/Caregiver information:

- ☐ Biological
- ☐ Adoptive
- ☐ Foster
- ☐ Guardian/Conservator
- ☐ Court Appointmed Guardian
- ☐ Joint Legal Custody
- ☐ Sole Legal Custody
- ☐ Unaccompanied Youth/Minor
- ☐ Refugee
- ☐ Asylum Seeker
- ☐ N/A Emancipated Minor

39. *Child/Youth Member's nationality/tribe/ethnicity (Select all that apply):

- ☐ Hispanic or Latino
- ☐ Asian
- ☐ Pacific Islander/Native Hawaiian
- ☐ White
- ☐ Black/African American
- ☐ American Indian/Alaskan Native
- ☐ Other (list):

40. * Child/Youth Member's current level of education:

- ☐ Elementary School
- ☐ Junior High School
- ☐ High School
- ☐ Some College
- ☐ Completed College
- ☐ Technical School or Training
- ☐ N/A
- ☐ Other (list):

Question required to be completed

41. * Parent/guardian/caregiver highest level of education:

- ☐ Elementary School
- ☐ Junior High School
- ☐ High School
- ☐ Some College
- ☐ Completed College
- ☐ Technical School or Training
- ☐ N/A
- ☐ Other (list):

42. *Does the Child/Youth member have a caregiver assisting them?

- ☐ Yes
- ☐ No

**If Yes, list name and contact information:*

43. * Does the Child/Youth member have an In-Home Supportive Services (IHSS) Worker?

- ☐ Yes
- ☐ No

**If Yes,* IHSS Worker's name(s) *and contact information:*

44. * Does the Child/Youth member need a caregiver?

- ☐ Yes
- ☐ No

**If Yes, explain:*

45. * Does the Child/Youth member's caregiver need additional help or training to provide care?

- ☐ Yes
- ☐ No
- ☐ N/A
- ☐ Decline to answer

**If Yes, explain:*

***Question required to be completed**

46. * Additional family members or other caregivers assisting the Child/Youth Member (for example, daycare, nanny, family member, friends, siblings)?

☐ Yes
☐ No
☐ N/A
☐ Decline to answer

**If Yes, explain:*

47. * Does the Child/Youth Member have job?

☐ Yes
☐ No
☐ N/A
☐ Decline to answer

**If Yes, list job(s):*

*** If Yes to question, "Does the Child/Youth Member have a job?" select all that apply below:**

☐ Part-time
☐ Full-time
☐ Day Laborer

Proceed to Child/Youth Member Needs and Preferences window.

Child/Youth Member Needs and Preferences

48.*What is the Child/Youth member's most important issue or need right now, as related to health, wellness, living situation, or something else?

Question required to be completed

Contact Information

49. *Preferred place to receive mail:

50. Home phone(s):

51. Cell phone(s):

52. * Preferred method of contact (select all that apply):

- ☐ In-person
- ☐ Phone
- ☐ Email
- ☐ Text

53. *Email Address(es):

Emergency Contact

54. *Name

55. Relationship):

56. Cell phone(s):

Question required to be completed

Section 3. Health Literacy

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

57. * Does the Child/Youth member (or their parent/guardian/caregiver, if applicable) need education or resources to help them understand the Child/Youth member's care and treatment needs?

- ☐ Yes
- ☐ No
- ☐ N/A
- ☐ Decline to answer

58. * Does the Child/Youth member (or their parent/guardian/caregiver, if applicable) express needing help in filling out health forms?

- ☐ Yes
- ☐ No
- ☐ N/A
- ☐ Decline to answer

Section 4. Physical Health

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

59. * Has the Child/Youth member (or their parent/guardian/caregiver, if applicable) been told by a doctor or medical provider that they have any medical conditions?

- ☐ Yes
- ☐ No

* If **Yes**, please check all that apply:

- ☐ Asthma / Chronic Lung Disease
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Cleft Lip/Palate
- ☐ Congenital Health Defect
- ☐ Cystic Fibrosis
- ☐ Pre-diabetes
- ☐ Diabetes Type 1

Question required to be completed

☐ Diabetes Type 2
☐ HIV
☐ Hypertension (high blood pressure)
☐ Kidney Disease
☐ Muscular Dystrophy
☐ Physical Disability/Para/Quadriplegic/Amputation
☐ Seizure/Epilepsy
☐ Sickle Cell Disease
☐ Spina Bifida
☐ Organ Transplant
☐ Genetic Condition(s)
☐ Other Conditions Not Listed Above

*****Organ Transplant List:

*****Genetic Coditions List:

*Other Conditions Not Listed Above, list.

60. * Does the Child/Youth member have trouble with vision?

☐ Yes
☐ No

**If Yes, describe:*

61.* Glasses/Contacts:

☐ Yes
☐ No
☐ Need

****Question required to be completed***

62.* TTY (visual Support):

☐ Yes
☐ No
☐ Need

*Other:

63.* If the Child/Youth member has diabetes, was a Diabetic Eye Exam completed in the last year?

☐ Yes
☐ No
☐ N/A

64.* Does the Child/Youth member have trouble with hearing?

☐ Yes
☐ No

*If Yes, describe:

65.* Hearing Devices:

☐ Yes
☐ No
☐ Need

*If Yes, List:

66.*In General would the Child/Youth member (or their parent/guardian/caregiver, if applicable) say their physical health is:

☐ Excellent
☐ Very Good
☐ Good fair
☐ Poor
☐ Decline to answer

Question required to be completed

67. * Please give more information about why the Child/Youth member (or their parent/guardian/caregiver) chose this rating:

68. *Has the Child/Youth member been to the hospital, emergency room, or a skilled nursing facility in the past 12 months?

- ☐ Yes
- ☐ No
- ☐ N/A
- ☐ Decline to answer

*If Yes, how many times and what for (list all):

69.* Does the Child/Youth member have a regular primary health care provider or medical home?

- ☐ Yes
- ☐ No

If Yes, fill out the following information:

***Name of Primary Care Providers:**

Contact Name:

Office Address:

Purpose of Last Visit:

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

Question required to be completed

70.* Does the Child/Youth member have a regular dentist or dental home?

☐ Yes
☐ No

If Yes, fill out the following information:

***Name of Dentist:**

Contact Name:

Office Address:

Purpose of Last Visit:

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

71. * Does the Child/Youth member currently have any dental health issues or needs?

☐ Yes
☐ No
☐ N/A
☐ Decline to answer

72. * Does the Child/Youth member receive care from any additional providers/specialists (select all that apply):

☐ Cardiology
☐ Developmental-behavioral pediatrics
☐ Endocrinology
☐ Genetics
☐ Hematology
☐ Immunology.infectious disease
☐ Neurology
☐ Oncology

Question required to be completed

☐ Orthopedics
☐ Pulmonology
☐ Respite
☐ Physical Therapy
☐ Occupational Therapy
☐ Speech Therapy
☐ Feeding Therapy
☐ Other (list):

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

Medications

73. * List all the medications the Child/Youth member is currently taking:

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

Question required to be completed

74. If you were not able to list all medications above, list the missing medications below:

75.* Has the Child/Youth member (or their parent/guardian/caregiver, if applicable), had difficulty with filling the member's medications in the last year?

☐ Yes
☐ No

If Yes, explain why:

76.* Were there any days in the past week the Child/Youth member did not take medications as prescribed?

☐ Yes
☐ No

*If Yes, describe what gets in the way:

Question required to be completed

Pain and Symptom Management

77. * Does the Child/Youth member currently experience pain?

- ☐ Yes
- ☐ No
- ☐ Decline to answer

78. *During the past week, how much did the Child/Youth member's pain, or medical condition, interfere with normal activities (including going to school, playing with friends, or work outside the home and/or housework):

- ☐ Not at all
- ☐ A little bit
- ☐ Moderately
- ☐ Quite a bit
- ☐ Extremely
- ☐ Decline to answer

79. *Does the child/Youth member have supports, services, or routienes to help them manage their pain and/or medical condition(s) (e.g., palliative care provider, medication, therapies, medications, family/friend support)?

- ☐ Yes
- ☐ No
- ☐ Decline to answer

*If Yes, write below which supports, services, or routines the Child your member currently has:

Section 5. Pregnancy/Postpartum

80. If not completing this section, indicate below reason and then skip to *Section 6. Activities of Daily Living (ADLs)*:

- ☐ Questions not reviewed for the Child/Youth member (child has not reached puberty/first menstrual period)
- ☐ Questions not reviewed for the Child/Youth member (other reason – indicate reason)
- ☐ Other reason-indicate reason:

Question required to be completed

81. *Is the Child/Youth member currently pregnant?

- ☐ Yes
- ☐ No
- ☐ N/A
- ☐ Decline to Answer

82. *If Yes, how many weeks pregnant?

83. * Has the pregnancy been disclosed to the parent/guardian/caregiver?

- ☐ Yes
- ☐ No
- ☐ N/A

84. * Delivery:

- ☐ Know extepcted date of delivery
- ☐ Not sure
- ☐ Decline to Answer

***Expected date of delivery:** MM/DD/YYYY

*** First prenatal care appointment (date and weeks):**

- ☐ Knows first prenatal care appointment
- ☐ Not sure
- ☐ Decline to Answer

***First prenatal care appointment:** MM/DD/YYYY

Question required to be completed

85. Does the member have an OB or midwife?

- ☐ Yes
- ☐ No
- ☐ Decline to Answer

86. Does the member have a doula, or do they plan to have a doula?

- ☐ Yes
- ☐ No
- ☐ Decline to Answer

87. Does the member know where they plan to deliver the baby?

- ☐ Yes
- ☐ No
- ☐ Decline to Answer

88. Does the member plan to breastfeed?

- ☐ Yes
- ☐ No
- ☐ Unsure
- ☐ Decline to Answer

89. Has the member selected a pediatrician for the baby?

- ☐ Yes
- ☐ No
- ☐ Decline to Answer

If Yes, fill out the following information:

***Name of Primary care Provider**

***Contact Number**

Question required to be completed

*** Office Address**

90. Does the Child/Youth member have the essentials they need for when baby comes home from the hospital (e.g., car seat, formula, blankets, crib, clothes, diapers, bottles?

- ☐ Yes
- ☐ No
- ☐ Decline to Answer

*If **No**, list what the member needs:

91. Does the Child/Youth member plan to go to any birthing classes?

- ☐ Yes
- ☐ No
- ☐ Decline to Answer

92. Does the Child/Youth member need education/resources on pregnancy, breastfeeding and infant health?

- ☐ Yes
- ☐ No
- ☐ Decline to Answer

Postpartum Questions

93. Has the Child/Youth member given birth in the last 12 months?

- ☐ Yes
- ☐ No
- ☐ N/A
- ☐ Decline to Answer

Question required to be completed

94. Is the Child/Youth member working with a doula?

☐ Yes
☐ No
☐ Decline to Answer

*If **Yes**, fill out the following information:

*Name of Doula:

*Contact Number:

95. Is the Child/Youth member working with a lactation consultant?

☐ Yes
☐ No
☐ Decline to Answer

*If **Yes**, fill out the following information:

*Name of consultant:

*Contact Number:

96. Has the Child/Youth member had a postpartum appointment?

☐ Yes
☐ No
☐ Decline to Answer

* If **Yes**, fill out the date of the last appointment (if known):

Question required to be completed

97. Has the baby been going to their pediatrician for their appointment?

☐ Yes
☐ No
☐ Decline to Answer

*If **Yes**, fill out the following information:

*Name of provider:

*Contact Number:

*Office Address:

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

Section 6. Activities of Daily Living (ADLs) window

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

If the Child/Youth member's age is 0-5, does the Child/Youth member need help with any of these activities:

98. Eating (as developmentally or age-appropriate – e.g., chewing, swallowing, latch)

☐ Yes
☐ No
☐ Decline to Answer

99. Coordination/moving around (as developmentally or age appropriate)

☐ Yes
☐ No
☐ Decline to Answer

***Question required to be completed**

100. Using hands (as developmentally or age-appropriate)

- ☐ Yes
- ☐ No
- ☐ Decline to Answer

101. Toileting (as developmentally or age-appropriate – e.g., potty trained, dry through the night)

- ☐ Yes
- ☐ No
- ☐ N/A
- ☐ Decline to Answer

If the Child/Youth member's age is 6-18, does the Child/Youth member need help with any of these activities:

102. Bathing

- ☐ Yes
- ☐ No
- ☐ Decline to Answer

103. Grooming (brushing teeth & hair, washing hands & face)

- ☐ Yes
- ☐ No
- ☐ Decline to Answer

104. Dressing

- ☐ Yes
- ☐ No
- ☐ Decline to Answer

105. Toileting

- ☐ Yes
- ☐ No
- ☐ Decline to Answer

Question required to be completed

106. Eating

☐ Yes
☐ No
☐ Decline to Answer

107. Mobility (Walking, Climbing stairs)

☐ Yes
☐ No
☐ Decline to Answer

If the Youth member's age is 18-20, does the Youth member need help with any of these activities:

108. Taking a bath or shower

☐ Yes
☐ No
☐ Decline to Answer

109. Eating

☐ Yes
☐ No
☐ Decline to Answer

110. Brushing teeth, brushing hair, shaving

☐ Yes
☐ No
☐ Decline to Answer

111. Getting out of a bed or a chair

☐ Yes
☐ No
☐ Decline to Answer

112. Using the toilet

☐ Yes
☐ No
☐ Decline to Answer

Question required to be completed

113. Washing dishes or clothes

- ☐ Yes
- ☐ No
- ☐ Decline to Answer

114. Getting a ride to the doctor

- ☐ Yes
- ☐ No
- ☐ Decline to Answer

115. Going out to visit family or friends

- ☐ Yes
- ☐ No
- ☐ Decline to Answer

116. Going up stairs

- ☐ Yes
- ☐ No
- ☐ Decline to Answer

117. Getting dressed

- ☐ Yes
- ☐ No
- ☐ Decline to Answer

118. Making meals or cooking

- ☐ Yes
- ☐ No
- ☐ Decline to Answer

119. Shopping and getting food

- ☐ Yes
- ☐ No
- ☐ Decline to Answer

Question required to be completed

120. Walking

☐ Yes
☐ No
☐ Decline to Answer

121. Writing checks or keeping track of money

☐ Yes
☐ No
☐ Decline to Answer

122. Doing house or yard work

☐ Yes
☐ No
☐ Decline to Answer

123. Using the phone

☐ Yes
☐ No
☐ Decline to Answer

124. Keeping tack of appointment

☐ Yes
☐ No
☐ Decline to Answer

125. Has the member fallen in the last month?

☐ Yes
☐ No

126. Is the member afraid of falling?

☐ Yes
☐ No

Question required to be completed

127. Do the member's friends or family members express concerns about their ability to care for themselves?

☐ Yes
☐ No

Child/Youth member (any age)

128. If Yes to any of the above ADLs, is the Child/Youth member getting all the help they need with these actions?

☐ Yes
☐ No
☐ Decline to Answer

Comments:

129. Does the Child/Youth member use or need any of the following? (Select all that apply):

☐ Devices to help with mobility/transfers (e.g., wheelchair, lifts/seats, grab bar) (list):

☐ Devices to help with feeding/nutrition (e.g., feeding tube, special formula, food supplements) (list):

☐ Devices to help with continence (e.g., catheters, diapers, ostomy supplies) (list):

☐ Devices to help with airway/breathing (e.g., oxygen, ventilator, trach supplies) (list):

☐ Other (list):

Question required to be completed

130. * Does the Child/Youth member (or their parent/guardian/caregiver, if applicable) need help understanding how to use medical equipment?

- ☐ Yes
- ☐ No
- ☐ N/A
- ☐ Decline to Answer

Comments:

Section 7. Psychosocial, Mental, and Behavioral Health window

The following questions will be used to assess the Children/Youth member's current psychosocial, mental, and behavioral health needs and conditions.

131. *Has the healthcare or mental health provider ever told the Children/Youth member (or their parent/guardian/caregiver, if applicable) that they have a mental health diagnosis, or emotional or behavioral problem?

- ☐ Yes
- ☐ No
- ☐ N/A due the age of the child
- ☐ Decline to Answer

132. *If Yes, what diagnosis has the Child/ Youth member been given? (Select all that apply):

- ☐ Depression
- ☐ Bipolar Disorder
- ☐ Psychotic Disorder
- ☐ Anxiety
- ☐ Eating Disorder
- ☐ Other (list):

133. Comments, including how this currently affects the Child/Youth member's ability to manage daily activities:

***Question required to be completed**

134. If Yes, does the Child/Youth member currently have a provider that is treating them for this diagnosis?

- ☐ Yes
- ☐ No
- ☐ N/A
- ☐ Decline to Answer

*If **Yes**, fill out the following information:

*Name of provider:

*Contact Number:

*Office Address:

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

Social Interactions Questions

135. *How often does the Child/Youth member see or talk to people that they care about and feel close to? *(For example: talking to friends on the phone, visiting friends or family, going to church or club meetings).*

- ☐ Less than once a week
- ☐ 1 or 2 times a week
- ☐ 3 to 5 times a week
- ☐ 5 or more times a week
- ☐ N/A due to age of child/youth
- ☐ Decline to answer

136. * Over the past month (30 days), how many days has the Child/Youth member felt lonely?

- ☐ None- I never feel lonely
- ☐ Less than 5 days
- ☐ More than half the days (more than 15)
- ☐ Most days- I always feel lonely

Question required to be completed

☐ N/A due to age of child/youth
☐ Decline to answer

137. If parent/guardian/caregiver answering, are they interesting in parenting programs about their behavior or mood?

☐ Yes
☐ No
☐ N/A
☐Declined to Answer

Mental/Behavioral Health Assessment Questions

138. *Does the Child/Youth member (or their parent/guardian/caregiver, if applicable) have any concerns about their behavior or mood?

☐ Yes
☐ No
☐ N/A
☐Declined to Answer

139. * Yes, describe concerns here:

140. *Would the Child/Youth member (or their parent/guardian/caregiver, if applicable) like more information and or receive additional support regarding their mental/behavioral health?

☐ Yes
☐ No
☐ N/A
☐Declined to Answer

141. * Yes, indicate supports requested here:

For Child/Youth Members <u>Age 11 and Older</u> only

Depression- Patient health Questionnaire (PHQ-9) – For youth aged 11 and older. Check-off one option below and complete appropriate areas:

Question required to be completed

142. Does the Child/Youth member use or need any of the following? (Select all that apply):

☐ A recent (within past month) PHQ-9 has been completed by another provider and is in chart: (Enter Score here):

(Enter Score here):

☐ No PHQ-9 in chart. Complete the PHQ-2 Plus Question 9 section below. Follow scoring guidelines below.

☐ N/A

☐ Child/Youth Member (or their parent/guardian/caregiver, if applicable) declined to complete:

143. If reason was provided, enter here:

PHQ-2 Plus Question 9

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

144. * Have you experienced a reduction in interest or pleasure in doing things?

☐ Not at all
☐ Several Days
☐ More than half the days
☐ Nearly every day

145. * Have you felt down, depressed, or hopeless?

☐ Not at all
☐ Several Days

Question required to be completed

☐ More than half the days
☐ Nearly every day

146. * (Question 9) Thoughts that you would be better off dead or of hurting yourself in some way. ***Request for immediate consultation might be needed depending on response below*:**

☐ Not at all
☐ Several Days
☐ More than half the days
☐ Nearly every day

Scoring Guidelines:

- Not at all=0
- Several days=1
- More than half the days=2
- Nearly every day=3

For PHQ-2 Plus Question 9: Score of 2 or greater AND/OR selected "Several Days," or "More than half the days," or "Nearly every day," on Question 9- Complete the PHQ-9 Assessment (complete after this assessment has been submitted).* PHQ-9 scoring found within the *PHQ-9 Assessment.

If score indicates risk-factors are present, document actions taken (e.g., consultation, referrals for mental health assessment) ***via a contact form (Progress Notes) in CCA***.

Proceed to *Section 8. Substance Use* window

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

147. Child/Youth Member (or their parent/guardian/caregiver, if applicable):

☐ Decline to complete screening
☐ N/A-the Child/Youth member is too young to complete screening
☐ Wants to proceed with screening

In the past 6 months, how often has the Child/Youth member taken the following. (Responses required below if "*Wants to proceed with screening*" was selected above):							
Substance	**Never**	**1-2 Times**	**Monthly**	**Weekly**	**Daily**	**Date of Last Use**	**Is this substance use currently a**

***Question required to be completed**

							problem for them?
Alcohol	☐	☐	☐	☐	☐	MM/DD/YY	☐ Yes ☐ No
Nicotine products (cigarette, vaping, chewing tobacco)	☐	☐	☐	☐	☐	MM/DD/YY	☐ Yes ☐ No
Using prescription drugs not as prescribed (circle any relevant): • Pain medicines • ADHD medicines • Sleeping pulls	☐	☐	☐	☐	☐	MM/DD/YY	☐ Yes ☐ No
Marijuana	☐	☐	☐	☐	☐	MM/DD/YY	☐ Yes ☐ No
Other substances: For example, cocaine, meth, heroin, hallucinogens, inhalants, designer drugs	☐	☐	☐	☐	☐	MM/DD/YY	☐ Yes ☐ No

148. Has the Child/Youth member ever expressed wanting to cut down on drinking or drug us?

☐ Yes
☐ No
☐ N/A

Question required to be completed

☐Declined to Answer

149. *If Yes, would the Child/Youth member like to talk with someone about their substance use, especially if the member is thinking of quitting or cutting back?

☐ Yes
☐ No
☐ N/A

Comments:

Section 9. Developmental and Cognitive Functioning window

The following questions will be used to assess the Child/Youth member's current developmental and cognitive health needs and conditions.

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

☐ Yes
☐ No
☐ Decline to Answer

If **Yes**, what diagnosis has the Child/Youth member been given? Select as applicable.

☐ Intellectual disability
☐ Developmental disability
☐ Learning disability
☐ ADHD
☐ Autism spectrum disorder
☐ Other (list):

151. * Does the Child/Youth member currently have a provider that sees them for the condition(s) described above?

☐ Yes
☐ No
☐ N/A

Question required to be completed

☐Declined to Answer

If Yes, fill out the following information:

*Name of provider:

*Contact Number:

*Office Address:

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

Only answer questions relevant to the age of the Child/Youth member.

Child/Youth Member is <u>age 0-5</u> only:

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

☐ Yes
☐ No
☐ Decline to answer

*If Yes, list:

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

☐ Yes
☐ No
☐ Decline to answer

*If Yes, list:

Question required to be completed

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

☐ Yes
☐ No

Child/Youth Member is <u>age 6-18 (school-aged)</u> only:

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

☐ Yes
☐ No
☐ N/A
☐ Decline to answer

*If Yes, list treatment/supports services received:

155. Does the member (or their parent/guardian/caregiver, if applicable) have concerns about the Child/Youth member's learning?

☐ Yes
☐ No
☐ Decline to answer

*If Yes, describe:

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

☐ Yes
☐ No

156. Education Opportunities and Grants. If the Child/youth member is in foster care:

☐ Cal Grnt B for the Foster Youth
☐ Chafee Foster Youth Grant Program

Question required to be completed

☐ None
☐ Other

*Other (list):

Child/Youth Member is age 18-20 only:

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

☐ Yes
☐ No
☐ Decline to answer

158. In the past month, has the member ever felt worried, scared, or confused that something may be wrong with their mind or memory?

☐ Yes
☐ No
☐ Decline to answer

Section 10. Social Determinants of Health (SDoH) window

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

Housing

159. *Where does the Child/Youth member live? (Select all that apply):

☐ House
☐ Apartment complex
☐ Board and care facility
☐ Residential treatment center
☐ Group home
☐ Skill nursing facility
☐ Permanent supported housing
☐ Shared housing (i.e. couch surfing if loss of housing)
☐ Motel/hotel
☐ Trailer park

Question required to be completed

☐ Campground
☐ Emergency or transitional shelter
☐ Hospitalized with no safe dischrage plan
☐ Homeless
☐ Decline to answer
☐ Other

*Other (list):

160. *Does the Child/Youth member feel physically and emotionally safe where they currently live?

☐ Yes
☐ No
☐ Decline to Answer

161. *Is the Child/Youth member (and/or their parent/guardian/caregiver) worried about losing their housing?

☐ Yes
☐ No
☐ Decline to answer

*If Yes, describe:

162. *Is anyone currently helping the member (or their parent/guardian/caregiver, if applicable) with their housing support (for example, Housing navigator, case management, or tenants' rights)?

☐ Yes
☐ No
☐ N/A

163. *The Child/Youth member lives with?

☐ Biological parents
☐ Adoptive parent
☐ Foster parent
☐ Guardian/conservator
☐ Caregiver
☐ The Child/Youth member lives alone

Question required to be completed

164. If time is shared between living spaces, explain:

165. How many people live in the Child/Youth member's household (include ages and relationship to the Child/Youth member)?

166.*Highlight any other housing concerns that have not been identified above:

Environmental Safety

167. *Is the Child/Youth member and/or parent/guardian/caregiver concerned about living community?

☐ Yes
☐ No
☐ Decline to answer

*Comments:

168. *Is the Child/Youth member afraid of anyone or is anyone hurting them?

☐ Yes
☐ No
☐ Decline to answer

*If Yes, explain:

169. *Is anyone using the Child/Youth member's money without their permission?

☐ Yes
☐ No
☐ Decline to answer

Question required to be completed

*If Yes, explain:

170. *Child/Youth member exposure to substances in the home:

☐ Yes
☐ No
☐ Decline to answer

* If **Yes**, select below all that apply:

☐ Alcohol
☐ Narcotics
☐ Smoking/vaping/tobacco use
☐ Marijuana
☐ Other toxins

*Other toxins (describe):

Comments:

171. * Firearms/weapons in the home:

☐ Yes
☐ No
☐ Decline to answer

*If Yes, how are they stored:

172. *Can the Child/Youth member live safely and easily around their home?

☐ Yes
☐ No

Question required to be completed

☐ Decline to answer

173. *Does the place where the Child/Youth member live have?

***Good lighting:**

☐ Yes
☐ No

***Good heating:**

☐ Yes
☐ No

***Good cooling:**

☐ Yes
☐ No

***Rails for any stairs/ramps:**

☐ Yes
☐ No

***Hot water:**

☐ Yes
☐ No

***Indoor toilet:**

☐ Yes
☐ No

***A door to the outside, that locks:**

☐ Yes
☐ No

***Stairs to get into their home or stairs inside their home:**

☐ Yes
☐ No

***Elevator:**

☐ Yes
☐ No

Question required to be completed

***Space to use a wheelchair:**

☐ Yes
☐ No

***Clear ways to exit their home:**

☐ Yes
☐ No

***Lead paint:**

☐ Yes
☐ No

***Mold/mildew/dampness:**

☐ Yes
☐ No

***Overcrowding:**

☐ Yes
☐ No

***Unreliable utilities:**

☐ Yes
☐ No

***Mice, cockroaches, or other pests:**

☐ Yes
☐ No

***Additional housing and/or home environment safety concerns?**

☐ Yes
☐ No
☐ Decline to answer

*If Yes, explain:

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

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

Question required to be completed

174. Funding/benefit source/services that the Child/Youth member or the parent/guardian/caregiver (if applicable) uses (Select all that apply):

- ☐ CalFresh benefits (SNAP)
- ☐ TANF recipient
- ☐ School meals
- ☐ WIC
- ☐ SSI/SSDI recipient
- ☐ None
- ☐ Decline to answer

*If WIC, list site:

List any needs:

175. *Does the Child/Youth member (or their parent/guardian/caregiver, if applicable) sometimes run out of money to pay for any of the following necessities: food, rent basic utilities, phone and internet, clothing, childcare, medicine or other?

- ☐ Yes
- ☐ No
- ☐ Decline to answer

*If Yes, list:

176. **Does the Child/Youth member (or their parent/guardian/caregiver, if applicable) have transportation barriers?

- ☐ Yes
- ☐ No
- ☐ Decline to answer

*If Yes, list:

177. *Are there childcare barriers?

- ☐ Yes
- ☐ No
- ☐ N/A

Question required to be completed

☐ Decline to answer

*If Yes, list:

Section 12. Legal Environment

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

178. *In the past 12 months, has the Child/Youth member been involved with the following? (Select all that apply):

☐ Court ordered services
☐ On Probation
☐ On parole
☐ Re-entry program
☐ Dui/restricted license
☐ Adult Protective Services (APS)
☐ Child Protective Services (CPS)
☐ Community legal services
☐ None
☐ Other

*If Other, list:

179. *Comments (including any additional legal needs/resources):

180. *Does the child/Youth member have re-entry support provider and/or a parole/probation officer?

☐ Yes
☐ No
☐ N/A
☐ Decline to answer

181. If Yes, fill out the following information:

Question required to be completed

*Name of provider:	
*Contact Number:	
*Office Address:	
*Date of last visit (if known, or an approximate date):	

Section 13. End-of-life Planning window

These questions pertain to the Child/Youth member if they are age 18-20 only.

182. Does the member have a life-planning document or advance directive in place?

- ☐ Yes
- ☐ No
- ☐ Decline to answer

183. Do you want information on these topics?

- ☐ Yes
- ☐ No
- ☐ Decline to answer

184. If Yes, task Janna Hamilton "5 Wishes"

Proceed to *Narrative Summary* window.

Question required to be completed

Narrative Summary

185. List primary needs identified from the assessment:

Next Steps:	Person Responsible:
1.	
2.	
3.	

185. Next appointment/location:

186. Date Assessment Completed: MM/DD/YYYY

Question required to be completed