



Los Angeles County Children and Youth (C/Y) Enhanced Care Management (ECM) Comprehensive Assessment

Background Information

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

Section 1. Indicate the C/Y member's Population of Focus and other Los Angeles County Programs the C/Y member is involved in.

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

<p>Population of Focus for C/Y Member: <input type="checkbox"/> Experiencing Homelessness <input type="checkbox"/> At-Risk for Avoidable Hospital/ED Utilization <input type="checkbox"/> SMI/SUD <input type="checkbox"/> Transitioning from Youth Correctional Facility <input type="checkbox"/> CCS/CCS WCM <input type="checkbox"/> Child Welfare <input type="checkbox"/> I/DD <input type="checkbox"/> Pregnant/Postpartum <i>(As identified on the referral/authorization form)</i></p>
<p>Programs the C/Y Member is Involved in: <input type="checkbox"/> SMHS <input type="checkbox"/> DMC <input type="checkbox"/> DMC-ODS <input type="checkbox"/> Juvenile Justice <input type="checkbox"/> CCS <input type="checkbox"/> CCS WCM <input type="checkbox"/> Child Welfare <input type="checkbox"/> Regional Center Services <input type="checkbox"/> Local program serving pregnant/postpartum individuals (e.g., Comprehensive Perinatal Services Program [CPSP], California Home Visiting Program [HVP], etc.) (List): <input type="checkbox"/> Other(s), List: <input type="checkbox"/> N/A</p>
<p>Date of Consent for Opt-in to ECM services: _____ <input type="checkbox"/> Verbal <input type="checkbox"/> Written <input type="checkbox"/> C/Y Member <input type="checkbox"/> Parent/Guardian/Caregiver <input type="checkbox"/> DCFS <input type="checkbox"/> Court <input type="checkbox"/> Foster parent(s)</p>
<p>Is anyone else in the family enrolled in ECM? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list family member name(s), relationship(s) to C/Y member, and ECM Provider(s):</p>

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

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

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

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 C/Y Member's Needs / Preferences

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

C/Y Member Needs and Preferences		
What is the C/Y member's most important issue or need right now, as related to health, wellness, living situation, or something else?		
Contact Information		
Preferred place to receive mail:	Home phone(s):	Cell phone(s):
Preferred method of contact (select all that apply): <input type="checkbox"/> In-person <input type="checkbox"/> Phone <input type="checkbox"/> Email <input type="checkbox"/> Text	Email Address(es):	
Emergency Contact Name: Relationship: Contact Information:		

Section 3. Health Literacy

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

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

Section 4. Physical Health

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

Has the C/Y member (or their parent/guardian/caregiver, if applicable) been told by a doctor or medical provider that they have any medical conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please check all that apply: <input type="checkbox"/> Asthma/Chronic Lung Disease <input type="checkbox"/> Cancer <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Cleft Lip/Palate <input type="checkbox"/> Congenital heart defect <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Pre-Diabetes <input type="checkbox"/> Diabetes Type 1 <input type="checkbox"/> Diabetes Type 2 <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Hypertension (high blood pressure) <input type="checkbox"/> Kidney disease <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Physical disability/para/quadruplegic/amputation <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Organ Transplant (list): _____ <input type="checkbox"/> Genetic condition(s) (list): _____ <input type="checkbox"/> Other conditions not listed above (list): _____
Does the C/Y member have trouble with vision? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: _____ Glasses/Contacts: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Need TTY (visual support) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Need Other: _____
If the C/Y member has diabetes, has a Diabetic Eye Exam been done in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Does the C/Y member have trouble with hearing? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, describe: Hearing Device(s): <input type="checkbox"/> Yes (list): _____ <input type="checkbox"/> No <input type="checkbox"/> Need
In general, would the C/Y member (or their parent/guardian/caregiver, if applicable) say their physical health is: <input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Declined to Answer Please give more information about why the C/Y member (or parent/guardian/caregiver) chose this rating:
Has the C/Y member been to the hospital, emergency room, or a skilled nursing facility in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Declined to Answer If yes, how many times and what for? (list all): _____

Does the C/Y member have a regular primary health care provider or Medical Home? Yes No
 If yes, please fill out the following information:
 Name of Primary Care Provider:
 Contact Number:
 Office Address:
 Purpose of Last Visit:
 Date of Last Visit (if known, or an approximate date):

Does the C/Y member have a regular Dentist or Dental Home? Yes No
 If yes, please fill out the following information:
 Name of Dentist:
 Contact Number:
 Office Address:
 Purpose of Last Visit:
 Date of Last Visit (if known, or an approximate date):

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

Does the C/Y member receive care from any additional providers/specialists (mark all that apply):
Cardiology Developmental-Behavioral Pediatrics Endocrinology Genetics Hematology
Immunology/Infectious Disease Neurology Oncology Orthopedics Pulmonology Respite
Physical Therapy Occupational Therapy Speech Therapy Feeding Therapy
Other (list): _____
 If applicable, document name/contact information for each additional provider/specialist:

Medications

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

Medication Name	How Often (Frequency)	How Administered (Route)	Dosage

Please attach list for additional medications.

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

Were there any days in the past week the C/Y member did not take medications as prescribed? Yes No
 If yes, please describe what gets in the way:

Pain and Symptom Management

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

If yes, answer the questions below.
 During the past week, how much did the C/Y member's pain, or medical condition, interfere with normal activities (including going to school, playing with friends, or work outside the home and/or housework)?
Not at all A little bit Moderately Quite a bit Extremely Declined to Answer

Does the C/Y member have supports, services, or routines to help them manage their pain and/or medical condition(s) (e.g., palliative care provider, meditation, therapies [list], medications, family/friend support)? Write in the space below if applicable.
Yes No Declined to Answer
 If yes, please write below which supports, services, or routines the C/Y member currently has.

Section 5. Pregnancy/Postpartum

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

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

Questions not reviewed for C/Y Member (other reason – indicate reason: _____)

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

If no or N/A, skip to postpartum questions

If yes, how many weeks pregnant?

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

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

If yes to currently pregnant, please complete below

Expected Date of Delivery: _____ Not Sure Declined to Answer

First prenatal care appointment (date and weeks): _____ Not Sure Declined to Answer

Does the Member have an OB or midwife? Yes No Declined to Answer

Does the Member have a doula or do they plan to have a doula? Yes No Declined to Answer

Does the Member know where they plan to deliver the baby? Yes No Declined to Answer

Does the Member plan to breastfeed? Yes No Unsure Declined to Answer

Has the Member selected a pediatrician for the baby? Yes No Declined to Answer

If yes, please fill out the following information:

Name of Primary Care Provider:

Contact Number:

Office Address:

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

If no, list what the Member needs:

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

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

Yes No Declined to Answer

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

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

If yes, please fill out the following information:

Name of Doula:

Contact Number:

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

If yes, please fill out the following information:

Name of Consultant:

Contact Number:

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

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

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

If yes, please fill out the following information:

Name of Provider:

Contact Number:

Office Address:

Date of Last Visit (if known, or an approximate date):

Does the C/Y member need education/resources on post-pregnancy and infant health?

Yes No Declined to Answer

Section 6. Activities of Daily Living (ADLs)

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

Does the C/Y member need help with any of these activities?	
If C/Y member is 0-5 years old:	
Eating (as developmentally or age-appropriate – e.g., chewing, swallowing, latch) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer	Using hands (as developmentally or age-appropriate) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer
Coordination/moving around (as developmentally or age-appropriate) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer	Toileting (as developmentally or age-appropriate – e.g., potty trained, dry through the night) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Declined to Answer
If C/Y member is school-aged (6-18 years old):	
Bathing <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer	Grooming (brushing teeth & hair, washing hands & face) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer
Dressing <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer	Eating <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer
Toileting <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer	Mobility (walking, climbing stairs) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer
If C/Y member is 18+ years old	
Taking a bath or shower <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer	Going up stairs <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer
Eating <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer	Getting Dressed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer
Brushing teeth, brushing hair, shaving <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer	Making meals or cooking <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer
Getting out of a bed or a chair <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer	Shopping and getting food <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer
Using the toilet <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer	Walking <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer
Washing dishes or clothes <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer	Writing checks or keeping track of money <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer
Getting a ride to the doctor <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer	Doing house or yard work <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer
Going out to visit family or friends <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer	Using the phone <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer
Keeping track of appointments <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer	
Has the member fallen in the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you afraid of falling? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do the member's friends or family members express concerns about their ability to care for themselves? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes to any of the above ADLs, is the C/Y member getting all the help you need with these actions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer	
Comments:	
Does the C/Y member use or need any of the following? (Select all that apply):	
<input type="checkbox"/> Devices to help with mobility/transfers (e.g., wheelchair, lifts/seats, grab bar) (list): <input type="checkbox"/> Devices to help with feeding/nutrition (e.g., feeding tube, special formula, food supplements) (list): <input type="checkbox"/> Devices to help with continence (e.g., catheters, diapers, ostomy supplies) (list): <input type="checkbox"/> Devices to help with airway/breathing (e.g., oxygen, ventilator, trach supplies) (list): <input type="checkbox"/> Other (list):	
Does the C/Y (or their parent/guardian/caregiver, if applicable) need help understanding how to use medical equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Declined to Answer	
Comments:	

Section 7. Psychosocial, Mental, and Behavioral Health

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

<p>Has a healthcare or mental health provider ever told the C/Y member (or their parent/guardian/caregiver, if applicable) that they have a mental health diagnosis, or emotional or behavioral problem? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer <input type="checkbox"/> N/A due to age of child <i>If no, please skip to Social Interactions</i></p>
<p>If yes, what diagnosis has the C/Y member been given? <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Psychotic Disorder <input type="checkbox"/> Anxiety <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Other (list): Comments, including how this currently affects the C/Y member's ability to manage daily activities: Does the C/Y member currently have a provider that is treating them for this diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Declined to Answer If yes, please fill out the following information: Name of Provider: Contact Number: Office Address: Date of Last Visit (if known, or an approximate date):</p>
<p>Social Interactions</p>
<p>How often does the C/Y member see or talk to people that they care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings) <input type="checkbox"/> Less than once a week <input type="checkbox"/> 1 or 2 times a week <input type="checkbox"/> 3 to 5 times a week <input type="checkbox"/> 5 or more times a week <input type="checkbox"/> N/A due to age of child/youth <input type="checkbox"/> Decline to Answer</p>
<p>Over the past month (30 days), how many days has the C/Y member felt lonely? (Check one.) <input type="checkbox"/> None—I never feel lonely <input type="checkbox"/> Less than 5 days <input type="checkbox"/> More than half the days (more than 15) <input type="checkbox"/> Most days—I always feel lonely <input type="checkbox"/> N/A due to age of child/youth <input type="checkbox"/> Decline to Answer</p>
<p>(If Parent/Guardian/Caregiver answering) Are they interested in parenting programs about their child's development? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer</p>
<p>Mental/Behavioral Health Assessment Questions</p>
<p>For all C/Y Members:</p>
<p>Does the C/Y member (or their parent/guardian/caregiver, if applicable) have any concerns about their behavior or mood? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Declined to Answer Describe concerns here: Would the C/Y member (or their parent/guardian/caregiver, if applicable) like more information and or receive additional support regarding their mental/behavioral health? If yes, indicate supports requested.</p>
<p>For C/Y members 11 years and older</p>
<p>Depression – Patient Health Questionnaire (PHQ-9) – For youth aged 11 and older</p> <ul style="list-style-type: none"> • <i>If a recent (within past month) PHQ-9 has been completed by another provider and is in chart, enter score here: _____ and date: _____</i> • <i>If no PHQ-9 in chart, complete the PHQ-2+Q.9 below</i> • <i>Follow scoring guidelines below.</i> <p><input type="checkbox"/> N/A <input type="checkbox"/> Declined to Complete (and reason, if provided):</p>
<p>PHQ-2 plus Question 9</p>
<p>Over the last two weeks, how often have you been bothered by any of the following?</p>
<p>1. Have you experienced a reduction in interest or pleasure in doing things? Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day <input type="checkbox"/></p>
<p>2. Have you felt down, depressed or hopeless? Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day <input type="checkbox"/></p>
<p>3. (Q.9) Thoughts that you would be better off dead or of hurting yourself in some way Not at all <input type="checkbox"/> Several days <input type="checkbox"/> More than half the days <input type="checkbox"/> Nearly every day <input type="checkbox"/></p>

Scoring: Not at all = 0, Several days = 1, More than half the days = 2, Nearly every day = 3.

- **For PHQ-2+Q.9: Score of 2 or greater AND/OR checks YES on Q.9 — Individual completes the PHQ-9 (recommend self-administer). Printable PHQ-9 in multiple languages: <https://www.phqscreeners.com/>**
- **If PHQ-9 score is >10 consult with clinical consultant and supervisor. If >15 or positive for Q.9 request immediate consultation.**

If score indicates risk-factors are present, document actions taken (consultation, referral for mental health assessment):

Section 8. Substance Use

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

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

In the past 6 months, how often has the C/Y member taken the following:

Substance	Never	1-2 times	Monthly	Weekly	Daily	Date of Last Use	Is this substance use currently a problem for them?
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Nicotine Products (Cigarette, vaping, chewing tobacco)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Using Prescription drugs not as prescribed (circle any relevant): • Pain medicines • ADHD medicines • Sleeping pills Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Other substances: For example cocaine, meth, heroin, hallucinogens, inhalants, designer drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No
Have the C/Y member ever expressed wanting to cut down on drinking or drug use? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Declined to Answer							
If yes, the Member must complete the following question.							
Would the C/Y member like to talk with someone about their substance use, especially if the Member is thinking of quitting or cutting back? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A							
Comments:							

Section 9. Developmental and Cognitive Functioning

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

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

Yes No Declined to Answer

If no, skip to age-specific questions

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

Intellectual disability Developmental disability Learning Disability ADHD

Autism Spectrum Disorder

Other (list):

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

<p>Does the C/Y member currently have a provider that sees them for the condition(s) described above? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Declined to Answer</p> <p>If yes, please fill out the following information: Name of Provider: Contact Number: Office Address: Date of Last Visit (if known, or an approximate date):</p>
<p>If C/Y member is 0-5</p> <p>Is the Member enrolled in any early learning programs or in Early Intervention services? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer Is yes, list:</p>
<p>Does the Member's parent/guardian/caregiver have any concerns about their child's learning? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer</p> <p>Describe:</p> <p>Would the parent/guardian/caregiver like more information and to see somebody about their concerns?</p>
<p>If C/Y member is school-aged (6-18)</p> <p>Do the Member currently receive any treatment, supports or services related to this not identified elsewhere on this form (e.g., IEP or 504 Plan)?</p> <p><input type="checkbox"/> Yes; list treatment/supports/services received: <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Declined to Answer</p>
<p>Does the Member (or their parent/guardian/caregiver, if applicable) have concerns about the C/Y member's learning? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer</p> <p>Describe:</p> <p>Would the C/Y member (or their parent/guardian/caregiver, if applicable) like more information and to see somebody about their concerns?</p>
<p>Educational opportunities and grants: If C/Y member is in foster care: <input type="checkbox"/> Cal Grant B for Foster Youth <input type="checkbox"/> Chafee Foster Youth Grant Program <input type="checkbox"/> Other (list):</p>
<p>If C/Y member is 18+</p> <p>Has the Member had any changes in thinking, remembering, or making decisions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer</p> <p>In the past month, has the Member ever felt worried, scared, or confused that something may be wrong with their mind or memory? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Declined to Answer</p>

Section 10. Social Determinants of Health (SDoH)

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

<p>Housing</p> <p>Where does the C/Y member live? (check all that apply) <input type="checkbox"/> House <input type="checkbox"/> Apartment complex <input type="checkbox"/> Board and care facility <input type="checkbox"/> Residential treatment center <input type="checkbox"/> Group Home <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Permanent Supported Housing <input type="checkbox"/> Protective housing <input type="checkbox"/> Shared housing (i.e. couch surfing if loss of housing) <input type="checkbox"/> Motel/Hotel <input type="checkbox"/> Traylor Park <input type="checkbox"/> Campground <input type="checkbox"/> Emergency or Transitional Shelter <input type="checkbox"/> Hospitalized with no safe discharge plan <input type="checkbox"/> Homeless <input type="checkbox"/> Other: <input type="checkbox"/> Decline to Answer</p>

Does the C/Y member feel physically and emotionally safe where they currently live? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to Answer		
Is the C/Y member (and/or their parent/guardian/caregiver) worried about losing their housing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to Answer If yes, please explain:		
Is anyone currently helping the Member (or their parent/guardian/caregiver, if applicable) with their housing support (for example, Housing Navigator, case management, or tenants' rights)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
C/Y Member lives with: <input type="checkbox"/> Biological Parent <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Guardian/Conservator <input type="checkbox"/> Caregiver If time is shared between living spaces, please explain: How many people live in the C/Y member's household (include ages and relationship to C/Y member)? <input type="checkbox"/> C/Y member lives alone		
Please highlight any other housing concerns that have not been identified above:		
Environmental Safety		
C/Y member and/or parent/guardian/caregiver concerns about living community? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to Answer Comments:		
Is the C/Y member afraid of anyone or is anyone hurting them? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to Answer If yes, please explain:		
Is anyone using the C/Y member's money without their permission? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to Answer If yes, please explain:		
C/Y member exposure to substances in the home: <input type="checkbox"/> Alcohol <input type="checkbox"/> Narcotics <input type="checkbox"/> Smoking/vaping/ Tobacco use <input type="checkbox"/> Marijuana <input type="checkbox"/> Other toxins (describe): <input type="checkbox"/> Declined to Answer Comments:		
Firearms/weapons in the home: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to Answer If yes, how are they stored?:		
Can the C/Y member live safely and easily around their home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to Answer		
Does the place where the C/Y member live have:		
Good lighting: <input type="checkbox"/> Yes <input type="checkbox"/> No	Good heating: <input type="checkbox"/> Yes <input type="checkbox"/> No	Good cooling: <input type="checkbox"/> Yes <input type="checkbox"/> No
Rails for any stairs/ramps: <input type="checkbox"/> Yes <input type="checkbox"/> No	Hot water: <input type="checkbox"/> Yes <input type="checkbox"/> No	Indoor toilet: <input type="checkbox"/> Yes <input type="checkbox"/> No
A door to the outside that locks: <input type="checkbox"/> Yes <input type="checkbox"/> No	Stairs to get into their home or stairs inside their home: <input type="checkbox"/> Yes <input type="checkbox"/> No	Elevator: <input type="checkbox"/> Yes <input type="checkbox"/> No
Space to use a wheelchair: <input type="checkbox"/> Yes <input type="checkbox"/> No	Clear ways to exit their home: <input type="checkbox"/> Yes <input type="checkbox"/> No	Lead paint: <input type="checkbox"/> Yes <input type="checkbox"/> No
Mold/mildew/dampness: <input type="checkbox"/> Yes <input type="checkbox"/> No	Overcrowding: <input type="checkbox"/> Yes <input type="checkbox"/> No	Unreliable utilities: <input type="checkbox"/> Yes <input type="checkbox"/> No
Mice, cockroaches, or other pests: <input type="checkbox"/> Yes <input type="checkbox"/> No	Additional housing and/or home environment safety concerns? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to Answer If yes, please explain:	

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

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

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

Section 12. Legal Involvement

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

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

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

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

Narrative Summary

<p>Include Primary Needs identified from Assessment:</p> 	
Next Steps	Person Responsible
1.	
2.	
3.	
Next Appointment/Location:	