**Client Name**:       **Case #:**

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

**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)*

Choose an item.

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 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):*

**MEASURES USED FOR ASSESSMENT:**

**\*Select the ones that apply:**

BSID-III *(Bayley Scales of Development)*

DAS-II *(Differential Ability Scales)*

WPPSI-IV *(Preschool/Primary Scale)*

ABAS-II *(Adaptive Behavior Assessment)*

VABS-II *(Vineland Adapt. Scale)*

VABS-III *(Vineland Adapt. Scale)*

Informal Assess. Of Gross Motor Skills

CSBS *(Comm/Symbolic Behav. Scale)*

CBCL *(Child Behavior Checklist)*

ACE *(Adverse Childhood Experiences Survey)*

VMI *(Visual Motor Integration)*

ASQ-SE *(Ages/Stages Questionnaire)*

PSI *(Parenting Stress Inventory Short)*

SCQ *(Social Comm. Current Version)*

SCQ *(Social Comm. Lifetime Version)*

SRS-2 *(Social Response Scale Preschool)*

ADOS-2 (Autism Diag/Observe Schedule)

BRIEF-P *(Beh. Rate of Exec Function)*

K-CPTII *(Conner Kiddie Perform Test)*

M-CHAT *(Mod Check for Autism Toddler)*

BASC *(Beh Assess System for Children II)*

NESPY-II

C-TRF *(Caregiver-Teacher Report Form)*

NICHQ VAS-TI *(Vanderbilt Teacher)*

NICHQ VAS-PI *(Vanderbilt Parent)*

NNNS NICU Network Neurobehavioral Scale

ADHD Rating Scale IV *(Preschool)*

Connor’s Early Childhood – Parent

Connor’s Early Childhood – Teacher

Test of Early Reading Ability III

BASC III

ECADDES

Other\*\*\*

**CLINICAL FORMULATION**: *(Summarize clearly and with specific details (i.e. AEB, client statements or examples), how scoring in the high-risk range on a trauma screening tool, involvement with CWS, the Juvenile justice or homelessness results in a high risk for a mental health disorder OR with clear details state significant impairment(s) or the reasonable probability of significant deterioration in an important area(s) of life functioning or the interference(s) with appropriate developmental progress. Justify MH ICD-10 diagnosis or suspected diagnosis if not yet determined or based on the assessment of a Licensed MH professional, if at risk of a future mental health condition due to significant trauma. Document proposed service(s) to meet client’s needs and if applicable, address both MH and SUD 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 or parent/guardian at intake or change of address:**

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

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

Signature

Printed Name       CCBH ID number:

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

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

Signature

Printed Name       CCBH ID number:

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

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

Signature

Printed Name       CCBH ID number: