Mount Sinai Health Home

Mount Sinai Health Home Serving Children Comprehensive Assessment

Child/Youth's Name: ___________________________________ DOB: ______________________

Demographic Information	
Child's Name	
Child's DOB	
Child's Address	
Child's Phone	
Child's email	
Child's Preferred Language	
Child's Secondary Language	
Child's Race	
Ethnicity/Cultural Background	
Spirituality/Faith	Do you have any religious affiliations? ☐No ☐Yes. Specify:
Cultural/Spiritual Considerations	Are there any cultural or religious preferences that will impact Health Home participation or service delivery? ☐No ☐Yes. Explain:
Gender Identity	
Sexual Orientation	
Gender Expression	
Primary Caregiver's Name	
Primary Caregiver's Relationship to Child	
Primary Caregiver's Address (if different from child)	
Primary Caregiver's Phone	
Primary Caregiver's email	
Primary Caregiver's Preferred Language	
Additional Caregiver's Secondary Language	
Additional Caregiver's Name	
Additional Caregiver's Relationship to Child	
Additional Caregiver's Address (if different from child)	
Additional Caregiver's Phone	
Additional Caregiver's email	
Additional Caregiver's Preferred Language	
Additional Caregiver's Secondary Language	
Is a Translator Needed?	☐No ☐Yes. Explain:
Literacy	Are there literacy concerns or needs? ☐No ☐Yes. Explain:

Child/Youth's Name: ____________________________________ DOB: _______________________

<table>
<tr><td>Foster Care</td><td colspan="4">Is Child in Foster Care? ☐No ☐Yes. If yes:
Voluntary Foster Care Agency:
Address:
Caseworker:
Phone Number:</td></tr>
<tr><td colspan="5">Insurance</td></tr>
<tr><td>Medicaid Type</td><td colspan="4">☐ Fee for Service
☐ Managed Care Plan
Managed Care Plan:
Contact Name:
Contact Phone:</td></tr>
<tr><td colspan="5">Support System</td></tr>
<tr><td>List Household members</td><td colspan="4"><u>Name</u> <u>Relationship</u> <u>Age</u></td></tr>
<tr><td rowspan="4">List Other Informal Supports</td><td>Name and Relationship to Child</td><td>Contact Information</td><td>Support Provided</td><td>Consent?</td></tr>
<tr><td></td><td></td><td></td><td>❐ DOH-5201
❐ HIPAA Consent
❐ No</td></tr>
<tr><td></td><td></td><td></td><td>❐ DOH-5201
❐ HIPAA Consent
❐ No</td></tr>
<tr><td></td><td></td><td></td><td>❐ DOH-5201
❐ HIPAA Consent
❐ No</td></tr>
<tr><td colspan="5">Housing</td></tr>
<tr><td>Type of Housing/Risk of Eviction</td><td colspan="4">What is your current living situation?

☐Hotel/Motel ☐Subsidy/Emergency Shelter voucher ☐Emergency Shelter (non SRO)
☐Supportive Housing Program: Supportive Housing Program:___________________
Supporting Housing Case Manager: __________________
☐Rental/Coop/Condo/House ☐Staying with friends/family ☐Foster Home/Group Home
☐Hospital/Institution/Facility ☐ Other: ________________________

Since what date have you been in your current living situation? _________________

How many times has the child/youth and caregiver moved in the last Year?

Does the child/youth or caregiver need help with housing? ❐ No ❐ Yes. Explain:</td></tr>
</table>

Child/Youth's Name: ___________________________________ DOB: ______________________

	Does the child/youth or caregiver have current housing issues? ❒ No ❒ Yes: ☐Doubled up in Unit ☐Health/Safety concerns ☐Eviction/Pending Eviction ☐Expanding household/Space issue ☐Conflict with other in the household? ☐Release from institutional setting ☐Other: _______________________
Quality of Housing	Does the child/youth or caregiver have concerns about the environmental conditions within the home or community? ❒ No ❒ Yes. Explain:
Legal Status	Is there a concern that the legal status of a household member will impact the current housing arrangement? ❒ Declined to answer ❒ No ❒ Yes. Explain:
Financial Resource/Benefits and Needs	
Current Resources	Income per month: $________________ ☐Pay/Salary/Regular Employment ☐Unemployment benefits ☐Alimony/child support payments ☐Veteran's benefits ☐Enhanced rent [circle] Section 8, HRA, DHS, Others:_________________ ☐Energy assistance ☐Social Security ☐Medicare/Medicaid ☐HASA ☐Public Assistance ☐SSI ☐SSD ☐Food Stamps ❒ WIC ☐TANF ☐Other entitlements:____________ PA/HASA Worker:___________________________ Telephone: _______________ Center:____________________ PA/HASA Supervisor: _______________________ Telephone Number: _______________________ Are you currently late with your rent? ☐No ☐Yes. Amount: Rental arrears reason: What are your total monthly expenses:$_____ Do you have a representative payee: ☐Yes Name:__________________ ☐No Are you interested in setting up direct-rent payments? ☐Yes ☐No Do you need a fair hearing/appeal process for any denials of entitlements? ❒ No ❒ Yes. Explain: When is your Medicaid recertification date? ______________ Do you have any spenddowns? ☐No ☐Yes Amount per month: $__________
Food Security	❒ Family has access to healthy foods ❒ Family does not have access to healthy foods. Concerns and barriers: ❒ HHCM provided information about the following food resources in the community: ❒ Provided family with the link to NYS DOH Nutrition Programs and Nutrition Related Information.
Financial Resource/Benefits and Needs For Follow-up	Needs: ❒ No ❒ Yes. Explain:

Child/Youth's Name: ___________________________________ DOB: _______________________

Emergency Contact		
Emergency Contact Name		Consent? ❒ DOH-5201 ❒ HIPAA Consent ❒ No
Emergency Contact Address		
Emergency Contact's Phone		
Emergency Contact's email		
Child and Family History		
Pregnancy and Birth History	Were there any complications during pregnancy? ❒ No ❒ Yes. Explain: ❒ Full-term Birth ❒Premature Birth Child's weight at birth? ______ lbs. ______ oz. Were there any complications during birth? ❒ No ❒ Yes. Explain: Were drugs or alcohol consumed during pregnancy? ❒ No ❒ Yes Explain: Post-partum depression? ❒ No ❒ Yes Explain:	
General health and well-being of the child's Primary Caregiver.	Physical Health: ❒ Declined to answer ❒ No ❒ Yes. Explain: Mental Health: ❒ Declined to answer ❒ No ❒ Yes. Explain: Developmental: ❒ Declined to answer ❒ No ❒ Yes. Explain: Substance Use: ❒ Declined to answer ❒ No ❒ Yes. Explain: Exposure to Trauma: ❒ Declined to answer ❒ No ❒ Yes. Explain: Mobility: ❒ Declined to answer ❒ No ❒ Yes. Explain: Other:	
Developmental Milestones (Obtain a copy of the child's growth chart if available for child 0-5 years old)	Approximate age that the child achieved these milestones: Rolled over ______ Crawled _______ Walked ______ Talked (two words) ______ Toilet Trained _______ Does the caregiver have concerns about the child's development in any of these areas: ❒Speech/Language ❒ Motor Skills ❒ Cognitive/Intellectual ❒Sensory ❒ Behavioral ❒ Emotional ❒ Social Explain:	
Educational History	Current School: Grade: Type of school/classroom setting: School Contacts (Teacher, Guidance Counselor, etc.)	

Child/Youth's Name: ___________________________________ DOB: _______________________

Name	Role	Contact

❒ General Education ❒ Special Education
IEP: ❒ No ❒ Yes Next IEP Meeting Date: __________________
Recommended Services:

Type	Frequency	Currently being Provided?

Are medical accommodations required? ❒ No ❒ Yes. Explain:

Has the child/youth experienced or perpetrated bullying? ❒ No ❒ Yes. Describe the nature of and details of the bullying as well as any current supports to address the bullying:

Other concerns and barriers (i.e. behavior, cognitive/intellectual functioning, learning disability, academic performance, service provision, etc.):

Strengths:

Needs: ❒ No ❒ Yes. Explain:

Extracurricular Activities/ Interests	Does the child have a talent, interest, or participate in extracurricular activities that provide pleasure and/or self-esteem ❒ No ❒ Yes. Explain: Strengths:

	Barriers: ❒ None ❒ Yes. List: Needs: ❒ No ❒ Yes. Explain:
Employment History	Does child/youth meet the minimum age requirement for employment or participation in a vocational rehabilitation program? ❒ No (skip to needs) ❒ Yes. If yes: Does the child/youth have a history of employment or participation in a vocational rehabilitation program (i.e. Ticket to Work, Welfare to Work)? ❒ No ❒ Yes. Explain: Interests: Strengths: Barriers: ❒ None ❒ Yes. List: Needs: ❒ No ❒ Yes. Explain:
Activities of Daily Living (ADLs)	What are child/youth's current strengths and needs with respect to basic self-care tasks (feeding, dressing, bathing, grooming, etc.)? What supports are in place to assist the child/youth? Does the child/youth require adaptive equipment/technology? ❒ No ❒ Yes. Explain:
Instrumental Activities of Daily Living (IDLs)	What are the child/youth's current strengths and needs with respect IDLs (managing finances, shopping, meal preparation, managing medications, housecleaning and managing mail/telephone communications)? What supports are in place to assist the child/youth?

Child/Youth's Name: ___________________________ DOB: ____________________

Transportation	Does the child/youth have access to transportation? ❒ Yes. Mode: ❒ No. Explain/Barrier: Is medical transportation required or needed? ❒ No ❒ Yes. Explain:
History of Trauma (To avoid undue stress to the child/youth, HHCM should use all available sources of information and avoid questioning the child/youth directly)	Has the child/youth been exposed to trauma or adverse experiences? ❒ No ❒ Yes. Explain: What are the child's trauma symptoms? Has the child/youth had a Complex Trauma determination? ❒ No ❒ Yes. If yes, list the name of the licensed professional who completed the assessments: Is this professional treating the child/youth? ❒ No ❒ Yes
Child abuse and Neglect	Has the caregiver ever had an ACS case? ❒ No ❒ Yes. If yes, reason for the case: Is the case currently open? ❒ No ❒ Yes. If yes: Name of ACS Worker: Telephone Number: Are there any behaviors by caregivers in the home that pose a risk to the child/youth? ❒ No ❒ Yes. Explain: Are there any indicators of physical abuse, sexual abuse or maltreatment? ❒ No ❒ Yes. Explain: If the answer is yes to either question above, what action is being taken by the HHCM?
Legal/Juvenile Justice	History of delinquent behavior? ❒ No ❒ Yes. Explain: Current legal situation and charges? ❒ No ❒ Yes. Explain:

Child/Youth's Name: ___________________________________ DOB: _______________________

<table>
<tr><td></td><td colspan="4">If applicable, Juvenile/Adult Court Information:

If Applicable, Juvenile Placement/Detention/Incarceration History:</td></tr>
<tr><td>Runaway Behavior</td><td colspan="4">Is there a history of runaway behaviors? ❒ No ❒ Yes. Explain:

If yes, when did the behavior occur and for how long?

If yes, were the authorities contacted and which ones (i.e. Police, ACS)?

What triggers runaway behavior?

Are there current concerns about runaway behavior and the means to run away?❒ No ❒ Yes. Explain:</td></tr>
<tr><td rowspan="4">List Other Informal Supports</td><td>Name and Relationship to Child</td><td>Contact Information</td><td>Support Provided</td><td>Consent?</td></tr>
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❒ HIPAA Consent
❒ No</td></tr>
<tr><td>Caregiver Concerns</td><td colspan="4">What are care taker's primary concerns regarding child/youth's health and wellness?</td></tr>
</table>

Child/Youth's Name: ___________________________________ DOB: _______________________

Medical Health	
PCP	Does the child/youth have a PCP? ☐No. The caregiver would like help in connecting with a medical provider: ☐Yes ☐No. Explain: ☐Yes Name of provider: Specialty: Facility name: Address: Phone: Email: Start date: _________________ Last visit date: _________________ ❒ DOH-5201 or 5055 ❒ HIPAA Consent ❒ No Consent
Specialist	☐ No specialist working with child/youth. ☐ Child/youth needs a specialist in: ☐ The child/youth is seen by the following specialist: Name of provider: Specialty: Facility name: Address: Phone: Email: Start date: _________________ Last visit date: _________________ ❒ DOH-5201 or 5055 ❒ HIPAA Consent ❒ No Consent
Specialist	☐ No specialist working with child/youth. ☐ Child/youth needs a specialist in: ☐ The child/youth is seen by the following specialist: Name of provider: Specialty: Facility name: Address: Phone: Email: Start date: _________________ Last visit date: _________________ ❒ DOH-5201 or 5055 ❒ HIPAA Consent ❒ No Consent
Specialist	☐ No specialist working with child/youth. ☐ Child/youth needs a specialist in: ☐ The child/youth is seen by the following specialist: Name of provider: Specialty: Facility name:

	Address: Phone: Email: Start date: ________________ Last visit date: ________________ ❒ DOH-5201 or 5055 ❒ HIPAA Consent ❒ No Consent
Eye Care	☐ No Need. ☐ Child/youth needs a referral ☐ Declined Referral ☐ The child/youth is seen by the following provider: Name of provider: Specialty: Facility name: Address: Phone: Email: Start date: ________________ Last visit date: ________________ ❒ DOH-5201 or 5055 ❒ HIPAA Consent ❒ No Consent
Dental Care	☐ None ☐ Child/youth needs a referral ☐ Declined Referral ☐ The child/youth is seen by the following dentist: Name of provider: Specialty: Facility name: Address: Phone: Email: Start date: ________________ Last visit date: ________________ ❒ DOH-5201 or 5055 ❒ HIPAA Consent ❒ No Consent
Current Diagnoses (Medical)	Diagnosis: Hospitalizations and/or other treatments: Symptoms and severity: Adherence to treatment: Illness is : ❒ Controlled ❒Uncontrolled
	Diagnosis: Hospitalizations and/or other treatments: Symptoms and severity:

	Adherence to treatment: Illness is : ❒ Controlled ❒Uncontrolled
	Diagnosis: Hospitalizations and/or other treatments: Symptoms and severity Adherence to treatment: Illness is : ❒ Controlled ❒Uncontrolled
	Diagnosis: Hospitalizations and/or other treatments: Symptoms and severity: Adherence to treatment: Illness is : ❒ Controlled ❒Uncontrolled
	Diagnosis: Hospitalizations and/or other treatments: Symptoms and severity: Adherence to treatment: Illness is : ❒ Controlled ❒Uncontrolled

Medications

NAME	DOSAGE	REASON	START	END	ACTIVE

Medication Concerns/Adherence	Person(s) responsible for administering the child/youth's medication: **[skip if no MEDICATIONS] MEDICATION ADHERENCE SCREENING:** *Add up the numbers that appear next to the answers selected for each question listed. A score greater than 10 suggests good medication adherence where as a score less than or equal to 10 indicates poor adherence.*

Child/Youth's Name: ___________________________________ **DOB:** ______________________

	How often does the child/youth have difficulty taking the prescribed medication on time? (No more than 2 hours before or after the time your doctor told you to take it) ❒ All of the time (1pt) ❒ Most of the time (2pts) ❒ Rarely (3pts) ❒ Never (4pts) On average, how many days per week does the child/youth miss at least one dose of the prescribed medications? ❒ Every day (1pt) ❒ 4-6 days/week (2pts) ❒ 2-3 days/week (3pts) ❒ 1 day/week (4pts) ❒ <1 day/week (5pts) ❒ Never(6pts) When was the last time the child/youth missed at least one dosage of the prescribed medications? ❒ Within the past week (1pt) ❒ 1-2 weeks ago (2pts) ❒ 3-4 weeks ago (3pts) ❒ 1-3 months ago (4pts) ❒ >3 months ago (5pts) ❒ Never (6pts) Medication issues or concerns: ❒No ❒Yes. Describe: Is the child/youth out of medications? ❒ Yes ❒ No Barriers to medication compliance: ❒None ❒Yes. Describe: The ❒caregiver and/or ❒ child/youth would like to talk to someone about the child/youth's medications: ❒Yes ❒No
Other Health	
Allergies	
Heath Promotion Needs	❒ Obesity. BMI ________ ❒ Diabetes ❒ Diet ❒ Nutrition ❒ Asthma ❒ Living with HIV/AIDS ❒ Physical Activity ❒ Other: The ❒caregiver and/or ❒ child/youth would like more information about health related topics. ❒No ❒Yes. Describe:
Health Related Strengths, Barriers and Needs	
Health Related Strengths, Barriers and Needs	Strengths: Barriers: ❒ None ❒ Yes. List: Needs: ❒ No ❒ Yes. Explain:

Child/Youth's Name: ___________________________________ DOB: _______________________

Mental Health	
Psychiatric History and Diagnoses	Diagnosis: Age of Onset: Hospitalizations and/or other treatments: Symptoms and severity: Adherence to treatment: Illness is : ❒ Controlled ❒Uncontrolled
	Diagnosis: Age of Onset: Hospitalizations and/or other treatments: Symptoms and severity: Adherence to treatment: Illness is : ❒ Controlled ❒Uncontrolled
	Diagnosis: Age of Onset: Hospitalizations and/or other treatments: Symptoms and severity: Adherence to treatment: Illness is : ❒ Controlled ❒Uncontrolled
Current Provider(s)	☐ No mental health provider ☐ Child/youth needs a mental health provider. Type: ☐ The child/youth is seen by the following provider: Name of provider: Specialty: Facility name: Address: Phone: Email: Start date: ________________ Last visit date: ________________ ❒ DOH-5201 or 5055 ❒ HIPAA Consent ❒ No Consent Frequency of treatment:

<table>
<tr><td></td><td>Adherence to Treatment:</td></tr>
<tr><td></td><td>☐ No mental health provider
☐ Child/youth needs a mental health provider. Type:
☐ The child/youth is seen by the following provider:
Name of provider:
Specialty:
Facility name:
Address:
Phone:
Email:
Start date: ________________ Last visit date: ________________
❒ DOH-5201 or 5055
❒ HIPAA Consent
❒ No Consent

Frequency of treatment:

Adherence to treatment:</td></tr>
<tr><td>Current Functioning/Symptoms</td><td>PHQ-2 (Children 12 and older)

<table>
<tr><td>Over the last 2 weeks, how often have you been bothered by any of the following problems?</td><td>Not at all</td><td>Several days</td><td>More than half the days</td><td>Nearly every day</td></tr>
<tr><td>1. Little interest or pleasure in doing things</td><td>0</td><td>1</td><td>2</td><td>3</td></tr>
<tr><td>2. Feeling down, depressed, irritable, or hopeless</td><td>0</td><td>1</td><td>2</td><td>3</td></tr>
</table>

If there is a positive response (a response other than not at all) to one or both questions, the HHCM must complete the PHQ-9 with the member. <u>There is no need to ask questions 1 & 2 again. The answers can be carried over to the PHQ-9.</u>

PHQ-9A
<table>
<tr><td>Over the last 2 weeks, how often have you been bothered by any of the following problems? (Please CIRCLE to indicate your answer)</td><td>Not at all</td><td>Several days</td><td>More than half the days</td><td>Nearly every day</td></tr>
<tr><td>1. Little interest or pleasure in doing things</td><td>0</td><td>1</td><td>2</td><td>3</td></tr>
<tr><td>2. Feeling down, depressed, irritable, or hopeless</td><td>0</td><td>1</td><td>2</td><td>3</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><td></td><td>
<table>
<tr><td>3. Trouble falling or staying asleep, or sleeping too much</td><td>0</td><td>1</td><td>2</td><td>3</td></tr>
<tr><td>4. Feeling tired or having little energy</td><td>0</td><td>1</td><td>2</td><td>3</td></tr>
<tr><td>5. Poor appetite, weight loss, or overeating</td><td>0</td><td>1</td><td>2</td><td>3</td></tr>
<tr><td>6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down</td><td>0</td><td>1</td><td>2</td><td>3</td></tr>
<tr><td>7. Trouble concentrating on things, such as school work, reading or watching television</td><td>0</td><td>1</td><td>2</td><td>3</td></tr>
<tr><td>8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been</td><td>0</td><td>1</td><td>2</td><td>3</td></tr>
<tr><td>9. Thoughts that you would be better off dead, or of hurting yourself in some way</td><td>0</td><td>1</td><td>2</td><td>3</td></tr>
</table>
PHQ-9A Score:</td></tr>
<tr><td>Self-Harm</td><td>Does child/youth have a history of self-harm behaviors (i.e. cutting, head-banging, hair pulling, etc.) ☐No ☐Yes. Explain:

If yes, date and details of most recent self-harm incident:

Does child/youth have a history of fire-setting (intentional or accidental)? ☐No ☐Yes. Explain:

Does the child/youth exhibit any problematic social behaviors? ☐No. ☐Yes Explain:</td></tr>
<tr><td>Suicide Risk Assessment</td><td>Has the child/youth ever had thoughts about taking his/her/their life? ☐No. ☐Yes
If yes: ☐ Past. Last time:
☐ Present. Does child/youth have a plan? ☐No. ☐Yes Action taken by HHCM:

Has child/youth ever attempted to kill him/her/their self? ☐No. ☐Yes. If yes, when?</td></tr>
</table>

Child/Youth's Name: ___________________________________ DOB: ______________________

	Has child/youth's self-injurious behaviors resulted in a crisis/ER assessment or mental health hospitalizations? ☐No history of self-injurious behavior. ☐No. ☐Yes. If yes, when? Explain:
Danger to Others	Does child/youth have a history of or recent aggressive assaultive behaviors? ☐No. ☐Yes. If yes, when? Explain: Does child/youth have a history of or recent homicidal ideation/threats? ☐No. ☐Yes. If yes, when? Explain: Has child/youth's homicidal ideation/aggressive/assaultive behaviors resulted in a crisis/ER assessment or mental health hospitalizations? ☐No history of homicidal ideation/aggressive/assaultive behaviors. ☐No. ☐Yes. If yes, when? Explain:
Eating Disorders	Does child/youth have any eating disorder diagnosis (i.e. anorexia, bulimia, obesity?) ☐No. ☐Yes. Diagnosis: Does the child/youth have any eating disorder symptoms (i.e. PICA, binge eating, hoarding food)? ☐No. ☐Yes. Explain: Does child have a treatment provider? ☐Not needed ☐No. ☐Yes. Provider contact listed under: ☐Specialist ☐ Mental Health Provider
Strengths and Barriers	Strengths: Barriers: ❒ None ❒ Yes. List:
Needs	Needs: ❒ No ❒ Yes. Explain:

Child/Youth's Name: ___________________________________ DOB: ______________________

<table>
<tr><th colspan="2">Substance Use</th></tr>
<tr><td>Drug and Alcohol Screening

CRAFFT Scoring: Each "yes" response in Part B scores 1 point.
A total score of 2 or higher is a positive screen, indicating a need for additional assessment.</td><td>PART A: During the PAST 12 MONTHS, did the child/youth:
1. Drink any alcohol (more than a few sips)?
(Do not count sips of alcohol taken during family or religious events.)
☐No ☐Yes. Number of Days:___

2. Smoke any marijuana or hashish? ☐No ☐Yes. Number of Days:___

3. Use anything else to get high?
("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff") ☐No ☐Yes. Number of Days: ___

Did the child/youth answered "yes" to any questions in PART A?
☐No → PART B: Ask CAR question only, then stop.
☐Yes → Ask all 6 CRAFFT questions.

1. Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs? ☐No ☐Yes

2. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
☐No ☐Yes

3. Do you ever use alcohol or drugs while you are by yourself, or ALONE?
☐No ☐Yes

4. Do you ever FORGET things you did while using alcohol or drugs?
☐No ☐Yes

5. Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?
☐No ☐Yes

6. Have you ever gotten into TROUBLE while you were using alcohol or drugs?
☐No ☐Yes</td></tr>
<tr><td>History of Substance use (includes alcohol and tobacco)</td><td>Does child/youth have a history of or recent substance use? ☐No. ☐Yes. If yes:
<table><tr><th>Substance and route of administration</th><th>Frequency and amount</th><th>Started</th><th>Last time used</th></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr><tr><td></td><td></td><td></td><td></td></tr></table>Is there any family history of substance use? ☐No ☐Yes. Explain:</td></tr>
</table>

Child/Youth's Name: ___________________________________ DOB: _______________________

Treatment History	Has child/youth received treatment? ☐No ☐Yes. If yes:
Impact of Substance Use	☐ **Child/youth has no history of substance use.** What is the social context of the child/youth's substance use? How does child/youth's substance use/dependence impact daily living? Does child/youth understand consequences of substance use? ☐No ☐Yes To what degree is child/youth motivated to change?
Strengths and Barriers	Strengths: Barriers: ❒ None ❒ Yes. List:
Needs	Is a referral for treatment needed? ☐No ☐Yes. Explain:
Emergency Planning	
Emergency/Safety Plan: (Fire, Health, Safety Issues, Natural Disaster and other Public Emergency)	❒ Child/Family does not have an Emergency/Safety Plan. ❒ HHCM to work on plan with family ❒ Family is not amenable to working on plan at this time. ❒ Child/Family has an Emergency/Safety Plan. ❒HHCM to obtain copy of plan ❒ HHCM obtained copy of plan ❒ Other (explain):

Facility/Provider	Treatment Type	Started	Discharge Date

Child/Youth's Name: ___________________________________ DOB: _______________________

HIV/AIDS, Sexual Behavior, and Intimate Partner Violence	
HIV/AIDS (Includes Protected Service for Child/youth ≥10)	Has the child/youth been tested for HIV/AIDS? ☐No ☐Yes Date: Result: If positive: CD4 Count: _____________ Date:_____________ Viral Load : _____________ Date: _____________ Does the child/youth/family understand the meaning of T-cell and VL count and how to read lab results? ☐No ☐Yes Was the child exposed to HIV perinatally or after birth? ☐No ☐Yes Does the child/youth need a referral for further HIV education/information? ☐No ☐Yes. Explain: Does the child/youth have a history of STIs, injecting substances, or unprotected sex? ☐No ☐Yes. Explain: Does the child/youth need information about obtaining condoms, PrEP, or PEP? ☐No ☐Yes. Explain: Does the child/youth need a referral for testing? ☐No ☐Yes
Sexual Behavior	Is the child/youth sexually active? ☐No ☐Yes. If yes, In the past 12 months: How often has the child/youth used condoms for vaginal? ☐Always ☐Mostly ☐Sometimes ☐Never ☐N/A How often has the child/youth used condoms for anal sex? ☐Always ☐Mostly ☐Sometimes ☐Never ☐N/A What are the barriers to condom use? ☐ None ☐Allergy ☐Doesn't like the feeling ☐Limited/No access ☐Substance use ☐Partner declined ☐Not sexually active What form of birth control does the child/youth use? Would the child/youth like more information about birth control? ☐No ☐Yes. Explain:
	Is the child/youth pregnant? ☐ N/A – child youth is a male ☐No ☐Yes. If yes, estimated due date: _______ Is the child/youth receiving prenatal care? ☐No ☐Yes Name of provider: Specialty: Facility name: Address: Phone: Email: Last visit date: ❒ DOH-5201 or 5055 ❒ HIPAA Consent ❒ No Consent

	Does the child/youth need a referral for prenatal care: ☐No ☐Yes Has the child/youth ever been pregnant? ☐No ☐Yes. Explain:
	Does the child/youth have any children? ☐No ☐Yes. If yes: Number of Children and Ages: Concerns/Needs:
	Has the child/youth been treated for a Sexually Transmitted Infections (STI) in the past year? ☐No ☐Yes. Explain:
Intimate Partner Violence	Is the child/youth in a relationship in which they feel they are being controlled? ☐No ☐Yes. Explain: Is the child/youth in a relationship in which they have been threatened, hurt or afraid? ☐No ☐Yes. Explain: Has the child/youth forcefully performed sexual activity on another person? ☐No ☐Yes. Explain: Has the child/youth forced someone else to perform sexual activity on themselves? ☐No ☐Yes. Explain:

Transitional Planning (*From Child CMA to Adult CMA)*
Are there transitional planning needs? ☐No ☐Yes. Explain:

Child/Youth's Name: ___________________________________ DOB: _______________________

Summary

Completed By: ____ Date: ____________________

Supervisor Review: ____ Date: _____________________