CHILD'S NAME:	DATE:

COMPLETED BY A QUALIFIED BEHAVIORAL HEALTH PROVIDER AS PART OF THE INITIAL ASSESSMENT

PRESENTING CONCERNS

Describe your child:

What concerns, needs or questions do you have regarding your child or what circumstances led you to seek services at this time?

How is this current situation affecting other family members?

What would you like to see happen or change to improve the current situation?

What is the most important thing we can do for you today?

HOUSEHOLD INFORMATION

Who lives at home all the time? Who lives there some of the time?

Who provides care for your child? Who is an important source of support or influence (include grandparents, extended family, childcare providers, teachers, physicians, and persons providing spiritual support)?

CHILD'S ROUTINES/ACTIVITIES

Sleep: How well does your child fall asleep, stay asleep, and wake up in the morning?

Eating: How well does your infant/child eat? Is the process mutually pleasurable? What and how much does your child eat? Any difficulties or sensitivities to certain foods, textures, smells, temperatures? Any feeding or nursing problems?

Elimination/Toileting: Any concerns with your infant's or child's elimination patterns? Is your child toilet trained or showing interest?

Sensory Responses: Does your child seem overly sensitive to any of these situations? If yes, explain:

a. Being bathed, having hair washed: _____
b. Wearing new clothes: _____
c. Swinging or being lifted in the air: _____
d. Loud noises or noisy situations, vivid colors, or bright lights: _____
e. Does your child demonstrate minimal response to the environment and/or attempts at social engagement (e.g., withdrawal, under-reactivity to sensations, limited exploration, poor motor planning, lethargy)? If yes, explain:

How does your child manage transitions and changes in routine?

Describe a typical day:

IDENTIFIED CONCERNS IN THIS AREA MAY TRIGGER A REFERRAL TO THE CHILD'S PRIMARY CARE PROVIDER AND THE ARIZONA EARLY INTERVENTION PROGRAM (FOR CHILDREN AGE BIRTH TO 3)

FAMILY SOCIAL HISTORY

This section can be the starting point for an expanded Strengths, Needs and Culture Discovery (SNCD), which is developed over the course of the Assessment process and on a continuing basis as additional needs are identified and strengths emerge over time. Refer to AHCCCS AMPM Policy 580: Child and Family Team Practice Attachment A: Guidelines for Strengths, Needs, and Culture Discovery Domains for additional information.

Family's Daily Activities & Community Involvement (Describe leisure and other family activities, recreation, social involvement, exercise, diet/nutrition, cultural, spiritual, and religious practices, beliefs, and traditions, etc.)

Family Relationships/ Social Supports (Describe living environment, family or other social/community supports and strengths):

(Identify specific people who may be supportive and helpful and who might be invited to be part of the child's ongoing Team)

Caregiver's Current Employment (check only one): ☐ Full Time ☐ Part Time ☐ Work Adjustment Training ☐ Transitional Employment Placement ☐ Unemployed ☐ Volunteer ☐ Unpaid Rehab activities ☐ Student ☐ Homemaker ☐ Retired ☐ Disabled ☐ Inmate of Institution ☐ Unknown (for caregiver up to 17 yrs. of age only)
Identify strengths or barriers that have influenced person's ability to work:

Family Needs (e.g., legal, social, economic, housing, basic living needs, medical, behavioral health, caregiver's educational needs, child-related needs including receipt of special education services):

MEDICAL AND BEHAVIORAL HEALTH HISTORY

Completed by the caregiver of the minor child with the assistance of behavioral health staff if preferred.

Primary Care Physician: _____ Phone: _____ Fax: _____

Address: _____ Date last seen by PCP:_____

THE FOLLOWING MEDICAL AND BEHAVIORAL HEALTH HISTORY INFORMATION IS PROVIDED FOR THE PERSON WHO IS SEEKING SERVICES:

Has your child ever been diagnosed with or treated for any of the following conditions? (Check all that apply)

☐ **No Known Medical History (74)**

Behavioral/Mental Health Conditions:
☐ ADD/ADHD [Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder] (1)
☐ Autism Spectrum (2)
☐ Behavioral Challenges (3)
☐ Cognitive/Developmental Disability (4)

Blood Related Conditions:
☐ Anemia; Sickle Cell Anemia (5)
☐ Blood clotting disorder (6)
☐ Blood vessel Disease in legs/feet (7)
☐ Diabetes; blood sugar problems (8)

Cancer Conditions:
☐ AIDS/HIV (9)
☐ Cancer that spread (10)
☐ Cancer/tumor that did not spread (11)
☐ Leukemia (12)
☐ Lymphoma (13)

Bone, Joint, or Muscle Conditions:
☐ Arthritis: Degenerative joint disease (14)
☐ Orthopedic Disorders
Specify: _____ (15)
☐ Paralyzed in legs and/or arms (16)
☐ Rheumatoid Arthritis (17)

Early Childhood Conditions:

☐ Birth Deformities (18)
☐ Colic (19)
☐ Chronic Ear Infections (20)
☐ Failure to Thrive in children (21)
☐ Feeding Problems:
specify_____ (22)
☐ Fetal Alcohol Syndrome/Effects (23)
☐ Genetic Disorders:
specify_____ (24)
☐ Intrauterine Drug/Alcohol Exposure (25)
☐ Intrauterine Growth Restriction (26)
☐ Low Birth Weight (27)
☐ Perinatal/Postnatal Complications (28)
☐ Prematurity (29)
☐ Shaken Baby Syndrome (30)
☐ Unexplained Crying (31)

Hearing/Vision:

☐ Vision Impairment (32)
☐ Hearing Impairment (33)

Heart or Heart Related Conditions:

☐ Artery disease in heart (234)
☐ Enlarged heart (35)
☐ Heart attack (36)
☐ Heart failure (37)
☐ Heart rhythm problems; have a pacemaker (38)
☐ Heart valve problems (39)
☐ High blood pressure (40)
☐ Stroke (41)

Liver Conditions:

☐ Hepatitis; Gallbladder disease (42)
☐ Jaundice (43)

Lung Related Conditions:

☐ Blood vessel disease in legs/feet (37)
☐ Blood clot in lung; COPD (38)
☐ Pulmonary [e.g., Asthma, Allergies] (39)
☐ Respiratory Syncytial Virus [RSV] (40)
☐ Sleep Apnea (41)
☐ Tuberculosis (42)
☐ Valley Fever (43)

Neurological Disorders:

☐ Head injury with lasting effects/Traumatic Brain Injury (44)
☐ Other Neurological Disorders [e.g., Seizures, Cerebral Palsy, Spina Bifida, Muscular Dystrophy, Multiple Sclerosis (45)

Stomach, Intestinal, or Kidney Conditions:

☐ Crohn's disease; Colitis; Inflammatory Bowel Disease (46)
☐ Kidney disease (47)
☐ Kidney failure; need dialysis (48)
☐ Lactose-intolerant (49)
☐ Stomach ulcers; stomach bleed (50)

Weight or Thyroid Conditions:

☐ Addison's Disease (51)
☐ Cushing's Syndrome (52)
☐ High Thyroid (53)
☐ Low Thyroid (54)
☐ Obesity; surgery for weight problem (55)
☐ Pancreatitis (56)
☐ Problems with potassium/sodium (59)
☐ Unable to gain/maintain weight due to medical condition (60)

Miscellaneous:

☐ Ingestion of Poisonous/toxic substances (61)
☐ Traumatic Injuries (62)

Does your child have any other medical conditions not listed here? ☐ No
☐ Yes, list and provide a description: _____

Describe any complications during **pregnancy**, at th time of delivery, or in the first year following the birth, for either the mother or baby: (including premature birth of child, postpartum depression of mother)
_____

List past **hospitalizations** for medical conditions that required an overnight stay, visits to the emergency room or urgent care:

Are your child's **immunizations** up to date? ☐ Yes ☐ Unknown at this time.
☐ No, explain:

List all medications that your **child** is currently taking for medical and behavioral health concerns (include prescription, over the counter, vitamins, herbs, homeopathic, naturopathic, traditional or alternative medicine remedies).
☐ **Unknown at this time**

NAME OF MEDICATION	DOSE/FREQUENCY	REASON FOR TAKING	WHEN STARTED? BY WHOM?
1)			
2)			
3)			
4)			

List and describe your **child's allergic reactions or side effects to any medications:**

Has your **child** ever been diagnosed or received any **behavioral health or early intervention services (e.g., Arizona Early Intervention Program, Division of Developmental Disabilities)**? If yes, describe:

Are you aware of any **family members** who currently receive or have received in the past **behavioral health, developmental, substance abuse, or major medical** services (outpatient, hospital, residential facility, detoxification center)? If yes, describe the type of treatment/services:

RISK ASSESSMENT/EMOTIONAL HEALTH RED FLAGS

Complete the following based on information obtained through documentation, interviews, and observations.

CHILD: (check all that apply)

- ☐ Excessive Fussiness/Irritability
- ☐ Sexualized Behaviors
- ☐ Sexualized Statements
- ☐ Excessive Tantrums
- ☐ Excessive Un-soothable Crying
- ☐ Flat/Constricted Affect
- ☐ Excessive Fearfulness
- ☐ Other: _____
- ☐ Feeding Disturbances
- ☐ Slow Weight Gain/Growth
- ☐ Sleep Disturbances
- ☐ Self Harm Behaviors
- ☐ Aggressive to Others
- ☐ Overactive
- ☐ Under Active
- ☐ Caregiver-Child Relationship Concerns

Provide a more detailed explanation for any of the above risk factors that apply:

CAREGIVER: (check all that apply) and identify Caregiver: _____

- ☐ Caregiver Behavioral Health Concerns
- ☐ Caregiver Medical Diagnosis
- ☐ Caregiver Cognitive Limitations
- ☐ Harmed or Felt Close to Harming Child
- ☐ Confirmed Abuse or Neglect of Child
- ☐ Predominantly Negative View of Child
- ☐ Limit Setting/Discipline Concerns
- ☐ Over/Under Protective of Child
- ☐ Lack of Follow through with Child's Health Appointments, Medications, Immunizations, Therapies
- ☐ Unrealistic/Inappropriate Developmental Expectations
- ☐ Other: _____

Provide a more detailed explanation for any of the above risk factors that apply:

ENVIRONMENTAL STRESSORS/TRAUMA EVENTS: (CHECK ALL THAT APPLY)

☐ Exposure to Violence
☐ Multiple Placements
☐ Homelessness
☐ Child Neglect/Deprivation
☐ Death/Loss of Relationship
☐ Child Removed (DCS)
☐ Poverty
☐ High Family Conflict
☐ Child Physically Harmed/Abused
☐ Child Sexually Harmed/Abused
☐ Frightening Events (e.g., injury, car accidents, natural disasters, threat to caregiver's safety)
☐ Other: _____

Provide a more detailed explanation for any of the above risk factors that apply:

There is an immediate safety risk for the child or for others close to the child ☐ No ☐ Yes Explain:

DEVELOPMENTAL SCREENING: Include result from a developmental screening tool; examples of tools can be found in AMPM Policy 581

REFERRAL TO THE CHILD'S PRIMARY CARE PROVIDER, THE ARIZONA EARLY INTERVENTION PROGRAM (FOR CHILDREN AGE BIRTH TO THREE), OR THE PUBLIC SCHOOL SYSTEM FOR CHILDREN AGED 3 TO 5 WHEN DEVELOPMENTAL CONCERNS ARE IDENTIFIED.

INITIAL IMPRESSIONS, MENTAL STATUS EXAM AND OBSERVATIONS OF CHILD-CAREGIVER RELATIONSHIP

The following clinical observations and impressions of the child and caregiver are to be noted if they occur naturally within the initial engagement session. A more thorough assessment of the child's relationships and mental status are to occur over time, across caregiving relationships and environmental settings in order to assist in the development of goals and intervention strategies:

1). Child's appearance and general presentation.

2). Child's reaction to changes: (new situations, presence of strangers, changes in activity/routine, brief separations/reunions with caregiver if naturally occurring).

3). Child's emotional & behavioral regulation:

a. Child's ability to self-soothe and manage frustrations:

b. Child's response to caregiver's attempt to soothe or console:

c. Child's response to nurturance and affection (molding and cuddling behavior, pushes away, etc.):

4). Child's relatedness to caregivers, other family members and examiner:

a. Level of eye contact, physical contact, comfort level around others, any preferences for specific persons:

b. How child seeks attention, interaction, comfort, affection from caregiver:

5). Child's ability to play/explore:

6). Caregiver's perception of the child:

7.) The caregiver's ability to read and respond to child's cues and willingness to interact with the child:

CLINICAL FORMULATION AND DIAGNOSES

A. CLINICAL FORMULATION*:*

Synthesize the information to:

1. Identify the strengths and needs of the child and family.

2. Prioritize the needs, allowing the family to identify what needs are to be addressed.

3. Provide support for the diagnostic impression as based on observations of the child, the family-child interaction and other pertinent information acquired through the assessment process including:
   a. Caregiver's perception of the child,
   b. How child uses caregiver (e.g., as stable and responsive to their needs),
   c. Consider how issues such as parental neglect or abuse, inconsistent availability of primary caregivers, or
   d. environmental situations that interfered with appropriate caregiving have impacted stable attachments.

B. DIAGNOSTIC SUMMARY (INCLUDE DSM-V CODE, DIAGNOSIS AND DSM V CRITERIA MET):

DSM-V Dx Code :	Diagnosis :
DSM-V Dx Code :	Diagnosis :
DC : 0-5 Code :	Diagnosis :
DC : 0-5 Code :	Diagnosis :
DSM V Criteria Met :	

INITIAL PLAN

Initial Clinical Impressions:

_____
_____

Initial Goal Statement, if appropriate:

_____

DESCRIPTION OF NEXT ACTION STEPS TO BE TAKEN	RESPONSIBLE PERSON/PROVIDER AGENCY TO ENSURE ACTION OCCURS	START DATE FOR THE ACTION
1.		
2.		

DESCRIPTION OF NEXT ACTION STEPS I WILL TAKE	RESPONSIBLE PERSON/PROVIDER AGENCY TO ENSURE ACTION OCCURS	START DATE FOR THE ACTION
1. Next appointment (date):	With: Location:	Appt. Time: _____ AM _____ PM
2.		

☐ Further assessments needed **AS CLINICALLY INDICATED**: _____

☐ Additional documentation (e.g., medical records, IEP, DCS or developmental reports, etc.) to be collected: _____

My Behavioral Health Provider is: _____ Phone: _____

In case of emergency, I can also call: _____ Phone: _____

☐ Yes, I am in agreement with the types and level of services included in the Initial Plan.
☐ No, I disagree with the types and/or levels of some or all of the services included in this plan (by checking this box, my child/family shall receive the services that I have agreed to receive and may appeal the treatment team's decision to not include all the types and/or levels of services that I have requested).
☐ I have received a Notice of Action (PM Form 5.1.1 if disagreement concerns a Title XIX/XXI covered service).
☐ **Yes, I have received a copy of this plan.**

INITIAL PLAN: <u>Service Plan Rights Acknowledgement for Individuals who are Title XIX/XXI</u>:

My child's service plan has been reviewed with me by my child's behavioral health provider. I know what services my child and family will be getting and how often. All changes in the services have been explained to me. I have marked my agreement and/or disagreement with each service above. I know that in most cases, any reductions, terminations, or suspensions (stopping for a set time frame) of current services shall begin no earlier than 10 days from the date of the plan. I know that I can ask for this to be sooner.

If I do not agree with some or all the services that have been authorized in this plan, I have noted that above. I know if the service asked for was denied, reduced, suspended, or terminated, that my child's behavioral health provider will give me a letter that tells me why the decision was made. That letter will tell me how to appeal the decision that has been made about my child's and family's services. The letter will also tell me how I can request continued services.

My child's behavioral health provider has told me how the appeal process works. I know how I can appeal service changes I do not agree with. I know that I can change my mind later about the services I agree with today. I know that if I change my mind before the changes go into effect, I will get a letter that tells me the reason my child's and family's services changed. The letter will also tell me about my appeal rights.

I know that if my child or family needs more services or other services than what we are getting, I can call my child's behavioral health provider, as identified above, to talk about this. My child's behavioral health provider will call me back within three working days. Once I have talked with my child's behavioral health provider, they will give me a decision about that request within 14 days. If the behavioral health provider is not able to make a decision about my request within 14 days, they will send me a letter to let me know more time is needed to make a decision.

Parent (print name)	Signature	Date
Guardian (if required) (print name)	Signature	Date
Other (specify relationship) (print name)	Signature	Date
Behavioral Health Servicing Provider (PRINT)	Name of Behavioral Health Personnel (PRINT)	
Signature of Behavioral Health Personnel with credentials, if applicable (BHT)	Date	Time: Begin/End
Behavioral Health Professional Reviewer (BHP) (PRINT)	Signature	
BHP Reviewer: Professional Credential(s)	Date	Time: Begin/End