Date:	Billing Time:	Location:	Service Type:	Interviewed: ☐ Child / Youth
Date:	Billing Time:	Location:	Service Type:	☐ Caregiver ☐ Social Worker

I. CHILD BEHAVIORAL / EMOTIONAL NEEDS - CURRENT PRESENTATION AND REASON FOR REFERRAL: *(include onset, duration, severity of symptoms)*

(Refer to CANS-SB Manual for detailed scoring information)

KEY: **0 = no evidence to believe item requires any action.** **1 = needs watchful waiting, monitoring or possibly preventive action.**
2 = needs action. Strategy needed to address problem/need. **3 = needs immediate / intensive action. Immediate safety concern / priority for intervention.**

	0	1	2	3		0	1	2	3		0	1	2	3
Psychosis	☐	☐	☐	☐	Conduct	☐	☐	☐	☐	Affect Dysregulation	☐	☐	☐	☐
Impulsivity / Hyperactivity	☐	☐	☐	☐	Adjustment to Trauma	☐	☐	☐	☐	Behavioral Regressions	☐	☐	☐	☐
Depression	☐	☐	☐	☐	Anger Control	☐	☐	☐	☐	Substance Use	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	Eating Disturbances	☐	☐	☐	☐	Somatization	☐	☐	☐	☐
Oppositional	☐	☐	☐	☐										

II. AREAS OF IMMEDIATE CONCERN / RISK BEHAVIORS: *(include date of onset and level of impairment [e.g., school suspension, law enforcement/ incarceration, crisis services, and hospitalization])*

	0	1	2	3		0	1	2	3		0	1	2	3
Suicide Risk	☐	☐	☐	☐	Sexual Aggression	☐	☐	☐	☐	Fire Setting	☐	☐	☐	☐
Self-Mutilation	☐	☐	☐	☐	Runaway	☐	☐	☐	☐	Social Behavior	☐	☐	☐	☐
Other Self-Harm	☐	☐	☐	☐	Delinquency	☐	☐	☐	☐					
Danger to Others	☐	☐	☐	☐	Judgment	☐	☐	☐	☐					

Screening Complete – Assessment Needed? ☐ Yes ☐ No (If yes, complete assessment. If no, refer to recommendation section.)

III. LIFE DOMAIN FUNCTIONING AND ACCULTURATION: (*Describe impact on self-care, home, school, and community. Please note whether the impairments are due to diagnostic symptoms/behaviors.)*

	0	1	2	3		0	1	2	3		0	1	2	3
Family	☐	☐	☐	☐	Medical	☐	☐	☐	☐	School Attendance	☐	☐	☐	☐
Living Situation	☐	☐	☐	☐	Sexuality	☐	☐	☐	☐	Language	☐	☐	☐	☐
Social Functioning	☐	☐	☐	☐	Sleep	☐	☐	☐	☐	Identity	☐	☐	☐	☐
Developmental	☐	☐	☐	☐	School Behavior	☐	☐	☐	☐	Ritual	☐	☐	☐	☐
Legal	☐	☐	☐	☐	School Achievement	☐	☐	☐	☐	Cultural Stress	☐	☐	☐	☐

IV. MENTAL STATUS: [☐ ***appearance,*** ☐ ***attitude,*** ☐ ***behavior,*** ☐ ***orientation,*** ☐ ***speech,*** ☐ ***intellectual func.,*** ☐ ***memory,*** ☐ ***thought processes/contents,*** ☐ ***perceptual anomalies (e.g., hallucinations),*** ☐ ***insight,*** ☐ ***judgment,*** ☐ ***mood, &*** ☐ ***affect]*** Checked items indicate no concerns and functioning is Within Normal Limits (WNL)

V. CHILD STRENGTHS: ***(include child / youth resources and attributes that contribute to well-being or goal attainment)***

KEY: 0 = Centerpiece strength 1 = Useful strength to build upon 2 = Identified strength requires development 3 = Strength not yet identified

	0	1	2	3		0	1	2	3		0	1	2	3
Interpersonal	☐	☐	☐	☐	Spiritual/Religious	☐	☐	☐	☐	Family	☐	☐	☐	☐
Talents/Interests	☐	☐	☐	☐	Well-Being (Emotional)	☐	☐	☐	☐	Relationship Permanence	☐	☐	☐	☐
										*Family Finding	☐	☐	☐	☐

***KEY for Family Finding: 0 = No Need 1 = Family Find started 2 = Family Find needed 3 = In immediate need**

RECOMMENDATIONS ☐ NO SERVICES INDICATED AT THIS TIME

Is the child / youth being considered for or has received specialty mental health services: WRAP, TBS, CIS? Yes ☐ No ☐
Has the child / youth had a psychiatric hospitalization or is being considered for group home (RCL 10 or above)? Yes ☐ No ☐
Has this child / youth had 3 or more placements within the past 24 months due to behavioral health needs? Yes ☐ No ☐

NON-MENTAL HEALTH SERVICES	MENTAL HEALTH SERVICES (*traditional outpatient therapy services)*	MENTAL HEALTH PROGRAMS (*comprehensive programs which include services)*
☐ Student Assistance Program ☐ IRC (Inland Regional Center) ☐ Education Liaison ☐ Primary Care Physician ☐ School District Testing ☐ Family Search & Engagement ☐ Other	☐ Continue Current Services ☐ Children and Family Services Contract Provider ☐ Fee For Service Provider ☐ Value Options SERVICES RECOMMENDED: ☐ Individual Therapy ☐ Family Therapy ☐ Child Psychiatry ☐ Other	☐ EIIS (Early Identification & Intervention Services) ☐ SATS (School Aged Treatment Services) ☐ SART (Screening, Assessment, Ref. & Tx) ☐ DBH Clinic ☐ GMH (General Mental Health) Clinic ☐ TAY Center (Trans. Aged Youth) ☐ CIS (Children's Intensive Services) ☐ TBS (Therapeutic Behav. Services) ☐ Success First / Early Wraparound ☐ Wraparound (SB163)

Potential Barriers to Accessing Services: ☐ Client Declined ☐ Caregiver Declined ☐ CFS Case Worker Declined ☐ Other:

Dependent Qualifies as a Core Practice Model Subclass Member ☐ Yes ☐ No

CLINICAL SUMMARY & RECOMMENDATIONS: ***(minimally include demographics, current living situation, presenting problem, current risk factors and specific recommendations)***

CLINICIAN / LPHA NAME/TITLE:	**CLINICIAN / LPHA Signature:** **DATE:**
HEALTHY HOMES SCREENING/ASSESSMENT San Bernardino County DEPARTMENT OF BEHAVIORAL HEALTH Confidential Patient Information See W&I Code 5328	**Name:** **Chart No:** **DOB:** **PROGRAM:** JCBHS (RU#36D31)