Children and Youth Enhanced Care Management Comprehensive Assessment

Background

This assessment is designed as a tool for you, as Lead Care manager, to assess children and youth (C/Y) member's health needs and help the C/Y member participate in the Enhanced Care Management benefit. Today and over the next one to three 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 one: Indicate the C/Y member's Population of Focus and other 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.

Population of Focus for C/Y member: ☐ Experiencing Homelessness
☐ At-risk for avoidable hospital/emergency department (ED) utilization ☐ Serious mental illness/substance use disorder (SMI/SUD)
☐Transitioning from Youth Correctional Facility
☐ California Children's Services/ Whole Child Model (CCS/ WCM)
☐ Child Welfare ☐ Intellectual or developmental disability (I/DD)
☐ Pregnant/postpartum *(As identified on the referral/authorization form)*

Programs the C/Y member is involved in: ☐ Specialty Mental Health services (SMHS)
☐ Drug Medi-Cal (DMC) ☐ Drug Medi-Cal Organized Delivery System (DMC-ODS) ☐ Juvenile Justice ☐ CCS
☐ CCS/WCM ☐ Child welfare ☐ Regional center services
☐ Local program serving pregnant/postpartum individuals (for example, Comprehensive Perinatal Services Program [CPSP], California Home Visiting Program [HVP], etc.) (List):
☐ Other(s), List
☐ N/A

Date of consent for opt-in to ECM services: ☐Verbal ☐Written
☐ C/Y member ☐ Parent/guardian/caregiver ☐ DCFS ☐Court ☐Foster parent(s)

Is anyone else in the family enrolled in ECM? ☐Yes ☐No
If yes, list family member name(s), relationship(s) to C/Y member, and ECM Provider(s):

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.

Assessment or tool		Date completed	
ACES or PEARLS *If no ACEs or PEARLS screening completed, refer to PCP/SW for screening.*	☐ Yes		☐ No ☐N/A
CANS Assessment[1]	☐ Yes		☐ No ☐N/A
PSC-35[2]	☐ Yes		☐ No ☐N/A

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Assessment or tool		Date completed	
Needs Evaluation Tool[3]	☐ Yes		☐ No ☐N/A
Youth Screening Tool[4]	☐ Yes		☐ No ☐N/A
(DPH Foster Care) Child Health Evaluation	☐ Yes		☐ No ☐N/A
Protective Factors Survey[5]	☐ Yes		☐ No ☐N/A
(DCFS) Multidisciplinary Assessment Team[6]	☐ Yes		☐ No ☐N/A
(CCS) Patient Care Assessment	☐ Yes		☐ No ☐N/A
(DDS) Regional Center Assessment	☐ Yes		☐ No ☐N/A
(Pregnant/Postpartum) CPSP Assessment	☐ Yes		☐ No ☐N/A
(Justice Involved) Re-entry Transition Plan	☐ Yes		☐ No ☐N/A
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 two: Demographics and C/Y member's needs/preferences

C/Y member and family demographics	
Primary point of contact for ECM services: ☐ C/Y member ☐ Parent/guardian/caregiver ☐ Other (list):	Person(s) you are speaking with to complete this assessment (select all that apply): ☐C/Y member ☐ Parent/guardian/caregiver ☐ Other (list):
Today's date:	C/Y member's name:
Date of birth:	Medi-Cal Managed Care (Medi-Cal) ID:
C/Y member's preferred name and/or pronouns:	C/Y member's gender identification:
Preferred written/spoken language (*What language are you most comfortable speaking and reading?):* C/Y member: Parent/guardian/caregiver:	Interpreter needed: ☐ Yes ☐ No Language:
Do you have any cultural, religious and/or spiritual beliefs that are important to your family's health and wellness? ☐ Yes ☐ No ☐ Declined to answer If yes, describe:	
Relationship status of C/Y member: ☐ N/A ☐ Single ☐ Married ☐ Divorced ☐ Domestic partnership ☐Widower ☐Other: ☐ Declined to answer	Relationship status of parent/guardian/caregiver: ☐ N/A ☐ Single ☐ Married ☐Divorced ☐ Domestic partnership ☐ Widower ☐ Other: ☐ Declined to answer
Parent/guardian/caregiver name: Contact Information: ☐ Biological ☐ Adoptive ☐ Foster ☐ Guardian/conservator ☐ Court appointed guardian ☐ Joint legal custody ☐ Sole legal custody ☐ Joint physical custody ☐ Sole physical custody ☐ Unaccompanied youth/minor ☐ Refugee ☐ Asylum seeker ☐ N/A emancipated minor	
C/Y member's nationality/tribe/ethnicity: Select all that apply. ☐ Hispanic or Latino ☐ Asian American ☐ Pacific Islander/Native Hawaiian ☐ White ☐ Black/African American ☐ American Indian/Alaskan Native ☐Other:	
C/Y member's current level of education: ☐ Elementary school ☐ Junior high school ☐ High school ☐ Some college ☐ College completed ☐ Technical school or training ☐ N/A Other (list):	

Parent/guardian/caregiver highest level of education: ☐ Elementary school ☐ Junior high school ☐ High school ☐ Some college ☐ College completed ☐ Technical school or training ☐ Other (list): ☐ N/A
Does the C/Y member have a caregiver assisting them? ☐ Yes ☐ No If provided, list name and contact information: Does the C/Y member have an in-home supportive services (IHSS) worker? ☐ Yes ☐ No If yes, provide the in-home supportive services (IHSS) worker's name(s) and contact information: _____ Does the C/Y member need a caregiver? ☐ Yes ☐ No If yes, explain: Does the C/Y member's caregiver need additional help or training to provide care? ☐ Yes ☐ No ☐ N/A ☐ 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)? ☐ Yes ☐ No ☐ N/A ☐ Declined to answer List:
Does the C/Y member have a job? ☐ Yes ☐ No ☐ N/A ☐ Declined to answer If yes, list: If yes, ☐ Part-time ☐ Full-time ☐ 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): ☐In-person ☐ Phone ☐ Email ☐ Text	Email address(es):	
Emergency contact:		
Relationship:		
Contact information:		

Section three: 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? ☐ Yes ☐ No ☐ N/A ☐ 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? ☐ Yes ☐ No ☐ N/A ☐ Declined to answer
Does the C/Y member (or their parent/guardian/caregiver, if applicable) express needing help in filling out health forms? ☐ Yes ☐ No ☐ N/A ☐ Declined to answer

Section four: 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? ☐ Yes ☐ No		
☐ Asthma/chronic lung disease	☐ Diabetes type 1	☐ Seizures/epilepsy
☐ Cancer	☐ Diabetes type 2	☐ Sickle cell disease
☐ Cerebral palsy	☐ HIV/AIDS	☐ Spina bifida
☐ Cleft lip/palate	☐ Hypertension (high blook pressure)	☐ Organ transplant (list):
☐ Congenital heart defect	☐ Kidney disease	☐ Genetic condition (list):
☐ Cystic fibrosis	☐ Muscular dystrophy	☐ Other conditions (list):
☐ Pre-diabetes	☐ Physical disability, para/quadriplegic amputation	

Does the C/Y member have trouble with vision? ☐ Yes ☐ No If yes, describe: _____
Uses glasses/contacts: ☐ Yes ☐ No ☐ Need
Uses TTY (visual support) ☐ Yes ☐ No ☐ Need
Other:

If the C/Y member has diabetes, has a diabetic eye exam been done in the last year? ☐ Yes ☐ No ☐ N/A

Does the C/Y member have trouble with hearing? ☐ Yes ☐ No
If yes, describe:
Hearing device(s): ☐ Yes (list): _____ ☐ No ☐ Need

In general, would the C/Y member (or their parent/guardian/caregiver, if applicable) say their physical health is:
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Declined to answer
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?
☐ Yes ☐ No ☐ N/A ☐ 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, 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 approximate date)	

Does the C/Y member have a regular primary dentist or dental home? ☐ Yes ☐ No If yes, fill out the following information:	
Name of dentist:	
Contact number:	
Office address:	
Purpose of last visit	
Date of last visit (if known, or 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	☐ Neurology	☐ Occupational therapy
☐ Developmental-behavioral pediatrics	☐ Oncology	☐ Speech therapy
☐ Endocrinology	☐ Orthopedics	☐ Feeding therapy
☐ Genetics	☐ Pulmonology	☐ Other (list):
☐ Hematology	☐ Respite	If applicable, document name/contact information for each additional provider/specialist.
☐ Immunology/infectious disease	☐ Physical therapy	

Medications

What medication(s) is the C/Y member currently taking:

Medication name	How often (frequency)	How administered (route)	Dosage

Attach a 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, 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) (for example, palliative care provider, meditation, therapies [list], medications, family/friend support)? Write in the space below if applicable.
☐ Yes ☐ No ☐ Declined to answer

If yes, write below which supports, services, or routines the C/Y member currently has:

Section five: Pregnancy/postpartum

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

☐ 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 ☐ 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, 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 ☐ Not sure ☐ Declined to answer
Has the member selected a pediatrician for the baby?	☐ Yes ☐ No ☐ Declined to answer
If yes to member has selected a pediatrician, 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 arrives (for example 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 yes, list requested education/resources:
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, fill out the following information:	
Name of doula:	
Contact number:	
Has the C/Y member had a postpartum appointment? ☐ Yes ☐ No ☐ Declined to answer If yes, fill out the following information:	
Name of provider:	
Contact number	
Office address:	
Date of last visit (if known, or appointment date):	
Does the C/Y member need education/resources on post-pregnancy and infant health? ☐ Yes ☐ No ☐ Declined to answer	

Section six: Activities of daily living (ADLs)

The following are questions regarding the C/Y member's ability to perform basic self-care activities; only complete questions 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 to 5 years old:	
Eating (as developmentally or age-appropriate – for example, chewing, swallowing, latch) ☐ Yes ☐ No ☐ Declined to answer	Using hands (as developmentally or age-appropriate) ☐ Yes ☐ No ☐ Declined to answer
Coordination/moving around (as developmentally or age-appropriate) ☐ Yes ☐ No ☐ Declined to answer	Toileting (as developmentally or age-appropriate – for example, potty trained, dry through the night) ☐ Yes ☐ No ☐ Declined to answer
If C/Y member is school-aged (6 to 18 years old):	

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

Section seven: 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.

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?
☐ Yes ☐ No ☐ Declined to Answer ☐ N/A due to age of child
If no, please skip to social interactions.

If yes, what diagnosis has the C/Y member been given? ☐ Depression ☐ Bipolar disorder
☐ Psychotic disorder ☐ Anxiety ☐ Eating disorder
☐ 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?
☐Yes ☐ No ☐ N/A ☐ Declined to Answer

If yes, fill out the information below:

Name of provider:	
Contact number:	
Office address:	
Date of last visit (if known, or an approximate date):	

Social interactions

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)
☐ Less than once a week ☐ 1 or 2 times a week ☐ 3 to 5 times a week ☐ 5 or more times a week
☐ N/A due to age of child/youth ☐ Declined to answer

Over the past month (30 days), how many days has the C/Y member felt lonely? (Mark one.)
☐ None—I never feel lonely ☐ Less than 5 days ☐ More than half the days (more than 15)
☐ Most days—I always feel lonely ☐ N/A due to age of child/youth ☐ Declined to answer

(If Parent/Guardian/Caregiver answering) Are they interested in parenting programs about their child's development?
☐ Yes ☐ No ☐ Declined to answer

Mental/behavioral health assessment questions

For all C/Y Members:

Does the C/Y member (or their parent/guardian/caregiver, if applicable) have any concerns about their behavior or mood? ☐ Yes ☐ No ☐ N/A ☐ 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:

For C/Y members 11 years and older

Depression – Patient Health Questionnaire (PHQ-9) – For youth aged 11 and older

- ***If a recent (within past month) PHQ-9 has been completed by another provider and is in chart, enter score here: _____ and date: _____***
- ***If no PHQ-9 in chart, complete the PHQ-2+Q.9 below***
- ***Follow scoring guidelines below.***

☐ N/A ☐ Declined to complete (and reason, if provided):

PHQ-2 plus Question 9 Over the last two weeks, how often have you been bothered by any of the following?
1. Have you experienced a reduction in interest or pleasure in doing things? ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
2. Have you felt down, depressed, or hopeless? ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
3. (Q.9) Thoughts that you would be better off dead or of hurting yourself in some way ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day
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://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 eight: 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 to 2 times**	**Monthly**	**Weekly**	**Daily**	**Date of Last Use**	**Is this substance use currently a problem for them?**
Alcohol	☐	☐	☐	☐	☐		☐ Yes ☐ No
Nicotine products (cigarettes, vaping, chewing tobacco)	☐	☐	☐	☐	☐		☐ Yes ☐ No
Using prescription drugs not as prescribed (circle any relevant): • Pain medicines • ADHD medicines • Sleeping pills • Other:	☐	☐	☐	☐	☐		☐ Yes ☐ No
Marijuana	☐	☐	☐	☐	☐		☐ Yes ☐ No
Other substances: For example, cocaine, meth, heroin, hallucinogens, inhalants, designer drugs. Specify:	☐	☐	☐	☐	☐		☐ Yes ☐ No
Has the C/Y member ever expressed wanting to cut down on drinking or drug use? ☐ Yes ☐ No ☐ N/A ☐ 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? ☐ Yes ☐ No ☐ N/A							
Comments:							

Section nine: 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:

Does the C/Y member currently have a provider that sees them for the condition(s) described above?
☐ Yes ☐ No ☐ N/A ☐ Declined to answer
If yes, complete the information below.

Has the C/Y member had a postpartum appointment? ☐ Yes ☐ No ☐ Declined to answer
If yes, fill out the following information:

Name of provider:	
Contact number	
Office address:	
Date of last visit (if known, or appointment date):	

If C/Y member is 0-5

Is the member enrolled in any early learning programs or in early intervention services?
☐ Yes ☐ No ☐ Declined to answer
Is yes, list:

Does the member's parent/guardian/caregiver have any concerns about their child's learning?
☐ Yes ☐ No ☐ Declined to answer
Describe:

Would the parent/guardian/caregiver like more information and to see somebody about their concerns?
☐Yes ☐No

If C/Y member is school-aged (6-18)

Does the member currently receive any treatment, supports, or services related to this not identified elsewhere on this form (for example., IEP or 504 Plan)?

☐ Yes List treatment/supports/services received:

☐No ☐ N/A ☐ Declined to answer

Does the Member (or their parent/guardian/caregiver, if applicable) have concerns about the C/Y member's learning?
☐ Yes ☐ No ☐ Declined to answer

Describe:

Would the C/Y member (or their parent/guardian/caregiver, if applicable) like more information and to see somebody about their concerns? ☐ Yes ☐ No ☐ Declined to answer

Educational opportunities and grants: If C/Y member is in foster care: ☐ Cal Grant B for Foster Youth ☐ Chafee Foster Youth Grant Program ☐ Other (list):
If C/Y member is 18+
Has the member had any changes in thinking, remembering, or making decisions? ☐ Yes ☐ No ☐ Declined to answer
In the past month, has the member ever felt worried, scared, or confused that something may be wrong with their mind or memory? ☐ Yes ☐ No ☐ Declined to Answer

Section 10: Social drivers of health (SDOH)

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

Housing
Where does the C/Y member live? (mark all that apply) ☐ House ☐ Apartment complex ☐ Board and care facility ☐ Residential treatment center ☐ Group home ☐ Skilled nursing facility ☐ Permanent supported housing ☐ Protective housing ☐ Shared housing (for example, couch surfing if loss of housing) ☐ Motel/hotel ☐ Trailer park ☐ Campground ☐ Emergency or transitional shelter ☐ Hospitalized with no safe discharge plan ☐ Homeless ☐ Other: ☐ Declined to answer
Does the C/Y member feel physically and emotionally safe where they currently live? ☐ Yes ☐ No ☐ Declined to answer
Is the C/Y member (and/or their parent/guardian/caregiver) worried about losing their housing? ☐ Yes ☐ No ☐ Declined 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)? ☐ Yes ☐ No ☐ N/A
C/Y Member lives with: ☐ Biological parent ☐ Adoptive parent ☐ Foster parent ☐ Guardian/conservator ☐ Caregiver ☐ C/Y member lives alone 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)?
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? ☐ Yes ☐ No ☐ Declined to answer Comments:

Is the C/Y member afraid of anyone or is anyone hurting them? ☐ Yes ☐ No ☐ Declined to answer
If yes, please explain:

Is anyone using the C/Y member's money without their permission? ☐ Yes ☐ No ☐ Declined to answer
If yes, please explain:

C/Y member exposure to substances in the home:
☐ Alcohol ☐ Narcotics ☐ Smoking/vaping/tobacco use ☐ Marijuana
☐ Other toxins (describe):
☐ Declined to Answer
Comments:

Firearms/weapons in the home: ☐ Yes ☐ No ☐ Declined to answer
If yes, how are they stored?:

Can the C/Y member live safely and easily around their home? ☐ Yes ☐ No ☐ Declined to answer
If no, please describe:

Does the place where the C/Y member live have:

Good lighting: ☐ Yes ☐ No	Good heating: ☐ Yes ☐ No	Good cooling: ☐ Yes ☐ No
Rails for any stairs/ramps: ☐ Yes ☐ No	Hot water: ☐ Yes ☐ No	Indoor toilet: ☐ Yes ☐ No
A door to the outside that locks: ☐ Yes ☐ No	Stairs to get into their home or stairs inside their home: ☐ Yes ☐ No	Elevator: ☐ Yes ☐ No
Space to use a wheelchair: ☐ Yes ☐ No	Clear ways to exit their home: ☐ Yes ☐ No	Lead paint: ☐ Yes ☐ No
Mold/mildew/dampness: ☐ Yes ☐ No	Overcrowding: ☐ Yes ☐ No	Unreliable utilities: ☐ Yes ☐ No
Mice, cockroaches, or other pests: ☐ Yes ☐ No	Additional housing and/or home environment safety concerns? ☐ Yes ☐ No ☐ Declined 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.

Funding/benefit source/services that the C/Y member or the parent/guardian/caregiver (if applicable) uses:
☐ CalFresh benefits (SNAP) ☐ TANF recipient ☐ School meals ☐ WIC (list site): _____ ☐ SSI/SSDI recipient List any needs:
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? ☐ Yes ☐ No ☐ Declined to answer
Transportation barriers: ☐ Yes ☐ No ☐ Declined to answer If yes, please list: Childcare barriers: ☐Yes ☐No ☐ Declined to answer If yes, please list:

Section 12: Legal involvement

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

In the past 12 months, has the C/Y member been involved with the following?	
☐ Court ordered services ☐ On probation ☐ On parole ☐ Re-entry program ☐ DUI/restricted license ☐ Adult Protective Services (APS) ☐ Child Protective Services (CPS) ☐ Community legal services ☐ None ☐ Other (list): Comments, (including any additional legal needs/resources): Does the C/Y member have a re-entry support provider and/or a parole/probation officer? ☐ Yes ☐ No ☐ Declined to answer If yes, fill out the information below:	
Name of provider:	
Contact number:	
Office address:	
Date of last visit, if known, or approximate date:	

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? ☐ Yes ☐ No ☐ Declined to answer
Do you want information on these topics? ☐ Yes ☐ No ☐ Declined to answer

Narrative summary

Include Primary Needs identified from assessment:	
Next steps	Person responsible
1.	
2.	
3.	
Next appointment/location:	