Enhanced Standardized Assessment (ESA) for Children and Youth

Child/Youth Full Name:
Pronouns:
Date of Birth: Click or tap to enter a date.
Age:
Gender: Choose an item.
Transgender: Choose an item.
Race: Choose an item.
Ethnicity: Choose an item..
County of Residence/DYS Region: Choose an item.
Parent/Primary Caregiver Name(s):
Child/Youth Insurance (primary, secondary, tertiary):
Regional Accountable Entity (RAE): Choose an item.
Behavioral Health Administrative Service Organization (BHASO): Choose an item.
Date Assessment was Requested/Referral Accepted:.Click or tap to enter a date.
Date Assessment was Completed: Click or tap to enter a date.
Name and Credentials of Assessor:
Name of Contracted Agency the Assessment was completed under:
Name and Credentials of Clinical Supervisor (if applicable):
Check the appropriate box:

- ☐ **Family First Prevention Services Act (FFPSA) ESA by a Qualified Individual**
- ☐ **The Children and Youth Mental Health Treatment Act (CYMHTA) ESA**
- ☐ **Medicaid ESA**

For collateral outreach and documentation please include the names, entities, and relationship to the youth of all individuals contacted, dates and type of communication that occurred, dates and types of outreach attempts if no communication occurred, and reasons when a communication and/or outreach did not occur (no release of information).

Tools used during the Assessment *(i.e. CANS which is required for all assessments, for children and youth in need of inpatient or residential SUD the ASAM is required, other clinical tools could include Columbia, PHQ9, GAD-7, etc.):*

Documentation Review *(include name of document, who/entity that completed the documentation, date of document, etc.):*

Date(s) child/youth interviewed or outreached (face-to-face either in the same room with or through a HIPAA compliant video technology platform is required for CYMHTA and Medicaid):

Date(s) and name(s) parent(s)/guardian(s) interviewed or outreached (*Please do not include phone numbers or other contact information here**;** If this collateral does not exist for this child/youth**,** please explain**)**:*

Date(s) and name(s) of other family members/natural supports interviewed or outreached *(do not include phone numbers or other contact information; if this collateral does not exist for this child/youth, please explain):*

Date(s) and name(s) of school staff interviewed or outreached *(only list "N/A" if this collateral does not exist for this child/youth):*

Date(s) and name(s) of behavioral health professionals interviewed or outreached *(only list "N/A" if this collateral does not exist for this child/youth):*

Date(s) and names of Case Management Agency (CMA) interviewed or outreached (*only list "N/A" if this collateral does not exist for this child/youth*):

Date(s) and name(s) of DHS Case Worker interviewed or outreached *(only list "N/A" if this collateral does not exist for this child/youth):*

Date(s) and name(s) of DYS Client Manager interviewed or outreached *(only list "N/A" if this collateral does not exist for this child/youth):*

Date(s) and name(s) of other individuals and their relation to child/youth interviewed or outreached such as CASA, Guardian ad Litem (GAL), Counsel For Youth (CFY), Mentor, Probation Officer, Diversion Officer etc. *(only list "N/A" if this collateral does not exist for this child/youth):*

For All Assessments

Chief Complaint/Presenting Problem Narrative *(reason for referral/request, what is going on for the child, youth, and/or family that has led them to this point, what the youth believes is/would be helpful to them):*

Life Functioning Narrative *(Ensure the inclusion of the following information: -Family Functioning -Living Situation -Interpersonal Relationships -Social Functioning and Activities -Recreational/leisure activities -Legal -Decision Making -Sexual Development -Sexuality and Gender Identity -Detailed Medical (Physical/Dental) -Sleep Activities -Eating):*

Intellectual/Developmental Narrative *(Ensure the inclusion of the following information: -Developmental Milestones -Early Childhood Notes -Developmental/Intellectual -Cognitive -Communication -Motor -Self Care/Daily Living -Autism Spectrum -In-utero considerations -Other intellectual/development needs/information):*

School Behaviors, Educational, Daycare, HeadStart or Early Intervention Information) *(Ensure the inclusion of the following information: -School functioning -Behavioral issues -Peer issues -Educational/academic attainment -Attendance -Educational Attainment; Note any relevant changes in performance. -IEP or 504 Plan Information. If considering Day Treatment, information from the school district is imperative since Day Treatment is an education setting with community-based treatment):*

Behavioral/Emotional Needs Narrative and Symptom Profile *(Ensure the inclusion of a description of the behavior/symptom presentation, including onset, duration, frequency, and severity of symptoms/behaviors: -Psychosis (thought disorder) -Impulsivity/Hyperactivity -Depression -Anxiety -Oppositional-Related Behavior -Attachment Difficulties -Anger Control -Conduct-Related Behavior -Regulatory -Age-related Atypical Behaviors -Sleep-related problems –Other Behavioral or Emotional needs/information):*

Traumatic/Stressful Life Events Narrative (*Ensure the inclusion of the following information: -Sexual Abuse -Physical Abuse -Neglect -Emotional Abuse -Medical Trauma -Natural or Manmade Disasters -Family Violence -Community/School Violence -Attachment Difficulty (difficulty forming appropriate relationships with adults or peers) -Disruptions in Caregiving/Attachment Losses -War/Terrorism Affected -Victim/Witness to Criminal Activity -Parental Criminal Behavior -Other traumatic/stressful life events concerns/information -loss/death):*

Adjustment to Trauma/Traumatic Stress Symptoms Narrative *(Ensure the inclusion of the following information: -Adjustment to Trauma -Emotional and/or Physical Dysregulation -Other behaviors impacting functioning. -Intrusion/Re-experiencing -Avoidance -Hyperarousal -Numbing -Dissociation -Traumatic Grief & Separation -Exploited -Prenatal Care -Exposure -Labor and Delivery -Birth Weight - Failure to Thrive-Other Adjustment to trauma concerns/information):*

Substance Use Disorder Narrative *(Ensure the inclusion of the following information: -Substance Use -Severity of Use -Duration of Use – Method of use -Stage of Recovery -Peer Influences -Environmental Influences -Parental/Caregiver Influences -Current/Previous Treatment Attempts, -Current openness to treatment -Other substance use needs/information):*

Danger to Self-Risk Behaviors Narrative *(Ensure the inclusion of the following information with onset, timeframes, duration, frequency, and severity: -Suicide Risk -Current/historical suicidal ideation, current plan, history or previous attempts, protective factors -Non-Suicidal Self-Injurious Behavior -Other Self-Harm (Recklessness) -Runaway (frequency of running, safety of destination, likelihood of return on own, planning) -Other Danger to Self (sexually risky or vulnerable behavior, gang involvement behavior):*

Danger to Others Risk Behaviors Narrative *(Ensure the inclusion of the following information with onset, timeframes, duration, frequency, and severity: -Sexual Aggression -Delinquent Behavior -Aggressive Behaviors- Violence toward others -Fire Setting -Animal Cruelty -Historical/Current homicidal ideation -Other Danger to Others (gang involvement, animal cruelty, access to weapons):*

Strengths Narrative *(Ensure the inclusion of the following strengths information: -Family Strengths -Interpersonal -Optimism -Educational Setting -Vocational -Talents and Interests -Spiritual/Religious -Community Life -Relationship Permanence -Natural supports -Resilience (including Persistence and Adaptability) -Playfulness (age appropriate) -Resourcefulness -Cultural Identity -Natural Supports -Empathy):*

Cultural Factors Narrative *(Ensure the inclusion of the following information: -Cultural Factors to be Aware of -Cultural Stress -Language and/or Literacy -Traditions and Cultural Rituals -Cultural Congruence -Cultural Differences Within the Family -Other needs or considerations):*

Transition Age Youth (Ages 14+ or as applicable) (*Ensure the inclusion of the following information: -Independent Living Skills -Meal Preparation -Shopping -Housework - Money management -Communication Device Use -Housing Safety -Parenting/Caregiving Roles -Knowledge of needs -Youth supervision -Youth involvement with care -Youth organization -Youth Marital/Partner Violence in home -Medication Adherence -Intimate Relationships -Transportation -Educational Attainment -Job functioning-Career Aspirations -Job Attendance -Job Performance -Job Relations):*

Mental Status Exam

☐ Check this box if N/A due to FFPSA Documentation review/phone interview. Required in all other circumstances.

Observations

Appearance: ☐Neat ☐ Disheveled☐ Inappropriate ☐ Bizarre ☐ Other

Speech: ☐ Normal ☐ Tangential ☐ Pressured ☐ impoverished ☐ Other

Eye Contact: ☐ Normal ☐ Intense ☐ Avoidant ☐ Other

Motor Activity: ☐ Normal ☐ Restless ☐ Tics ☐ Slowed ☐ Other

Affect: ☐ Full ☐ Constricted ☐ Flat ☐ Labile ☐ Other

Comments:

Mood

☐ Euthymic ☐ Anxious ☐ Angry ☐ Depressed ☐ Euphoric ☐ Irritable ☐ Other

Comments:

Cognition

Orientation Impairment: ☐ None ☐ Person ☐ Place ☐ Time ☐ Object

Memory Impairment: ☐ None ☐ Short-term ☐ Long-Term ☐ Other

Attention: ☐ Normal ☐ Distracted ☐ Other

Comments:

Perception

Hallucinations: ☐ None ☐ Auditory ☐ Visual ☐ Other

Other: ☐ None ☐ Derealization ☐ Depersonalization

Comments:

Thoughts

Suicidality: ☐ None ☐ Ideation ☐ Plan ☐ Intent ☐ Self-harm

Homicidality: ☐ None ☐ Aggressive ☐ Intent ☐ Plan

Delusions: ☐ None ☐ Grandiose ☐ Paranoid ☐ Religious ☐ Other

Comments:

Behavioral

☐ Cooperative ☐ Guarded ☐ Hyperactive ☐ Agitated ☐ Paranoid

☐ Stereotyped ☐ Aggressive ☐ Bizarre ☐ Withdrawn ☐ Other

Comments:

Insight

☐ Good ☐ Fair ☐ Poor

Comments:

Judgment

☐ Good ☐ Fair ☐ Poor

Comments:

Caregiver Resources and Needs Narrative *(Ensure the inclusion of the following information: -Supervision -Involvement with Care/Willingness to participate in treatment -Knowledge -Organization -Social Resources -Residential Stability -Medical/Physical -Mental Health -Substance Use -Developmental -Safety -Marital/Partner Violence in the Home -Caregiver Emotional Responsiveness -Caregiver Legal):*

Current/Previous Medications *(list in chronological order with current medications first, reason for medication, dosages, and prescriber, dates taken):*

History of and/or current child welfare involvement and DYS commitment, including prior placement *(provide information chronologically, most recent first to include what led to involvement, name of agency, how long with agency, services provided/resources linked to, history of referrals):*

Psychiatric Hospitalization(s) *(report in chronological order, include where, for how long, under what set of circumstances, progress, and discharge plan, if discharge plan followed/factors that prevented following of discharge plan):*

Current and Previous Behavioral Health Services *(provide current/past Behavioral Health Services including location and type of treatment, when services started & ended, what type of treatment, the provider, treatment goals, progress, outcomes and barriers in treatment):*

Current Case Management Agency/Medicaid Waiver Services *(provide information on which Home and Community-Based Services Waiver the child/youth is on, the status of waiver, and current/past waiver services receives)*

Current or Pending Legal or Juvenile Justice Information *(previous interactions with law enforcement, probation, diversion, legal convictions, pending court dates, etc):*

Diagnosis History *(diagnosis, dates given if known, who diagnosed, and if it is current)***:**

Current Barriers to Treatment *(include such things as transportation, financial, family schedule, engagement, mobility concerns, medical needs):*

Risk of being a victim of human trafficking *(clinical assessment for potential signs that she/he/they have been or are at risk of being a victim of human trafficking, using all information gathered from the child/youth, family, collateral information and outreach, documentation review, etc. This is not a direct question you ask the child/youth.)***:**

For All Assessments

Diagnosis as evaluated by the Assessor *(including ICD-10 Codes, formulation and individualized clinical rationale)***:**

For CYMHTA and Medicaid Only

Significant Findings of the Child and Adolescent Needs and Strengths (CANS) Tool

Items needing immediate, intensive actions (CANS items scoring a 3):

Items that interfere with daily functioning or require actions to address (CANS items scoring a 2):

Centerpiece strengths of the child, youth, and family (CANS strengths sections scoring a 0):

Useful strength of the child, youth, and family (CANS strengths sections scoring a 1):

The Children and Youth Mental Health Treatment ACT (CYMHTA Only)

Assessment Clinical Recommendations: *(What are the clinical recommendations, how are the clinical recommendations going to work to treat, correct, or ameliorate the conditions better than anything else and reduce the risk of out-of-home placement)*:

Clinical Rationale for Why Lower Levels of Care Cannot Meet the Child or Youth's Needs (*include all relevant information from your assessment including barriers to treatment, caregiver involvement history, caregiver needs, risk factors, environmental factors, etc.*):

Medicaid Enhanced Standardized Assessment Treatment and Service Planning Recommendations (Medicaid Only):

Assessment Clinical Recommendations and Considerations: *(What are the clinical recommendations, how are the clinical recommendations going to work to treat, correct, or ameliorate the conditions)*:

Clinical Rationale for Why Lower Levels of Care Cannot Meet the Child or Youth's Needs (*include all relevant information from your assessment including unsuccessful treatment history, barriers to treatment, caregiver involvement history, caregiver needs, risk factors, environmental factors, etc.*):

Please select one of the following:
☐ Psychiatric Residential Treatment Facility
☐ Qualified Residential Treatment Program
☐ Intensive Care Coordination with Intensive Home-Based Treatment
☐ Other Community-Based Services and Supports
☐ Other Level of Care

For All Assessments

_____

Assessor Signature
(*Type in Name and Credential, then sign on line)*

_____

Date of Signature

_____

Clinical Supervisor Signature, if applicable
(*Type in Name and Credential, then sign on line)*

_____

Date of Signature