Children and Youth (C/Y) Enhanced Care Management Comprehensive Assessment

This assessment is a tool for you, as Lead Care Manager, to assess a C/Y member's health needs and help the C/Y member participate in the Enhanced Care Management (ECM) benefit. From the initial and over the next 1-3 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 1. Indicate the C/Y member's Population of Focus and other County programs they are 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 the C/Y member:

☐ Experiencing homelessness ☐ At-risk for avoidable hospital/emergency department (ED) utilization
☐ Serious mental illness (SMI)/substance use disorder (SUD) ☐ Transitioning from youth correctional facility
☐ California Children's Services (CCS)/CCS Whole Child Model (WCM) ☐ Child welfare
☐ Intellectual/developmental disorder (DD) ☐ Birth equity *(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 (e.g., 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 ☐ Department of Children and Family Services (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 the 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.

☐ ACEs or PEARLS ☐ Yes. Date completed:_____ ☐ No ☐ N/A

If no ACEs or PEARLS screening completed: refer to PCP/SW for screening.

☐ CANS Assessment[1] ☐ Yes. Date completed:_____ ☐ No ☐ N/A
☐ PSC-35[2] ☐ Yes. Date completed:_____ ☐ No ☐ N/A
☐ Needs Evaluation Tool[3] ☐ Yes. Date completed:_____ ☐ No ☐ N/A
☐ Youth Screening Tool[4] ☐ Yes. Date completed:_____ ☐ No ☐ N/A
☐ (DPH Foster Care) Child Health Evaluation ☐ Yes. Date completed:_____ ☐ No ☐ N/A
☐ Protective Factors Survey[5] ☐ Yes. Date completed:_____ ☐ No ☐ N/A
☐ (DCFS) Multidisciplinary Assessment Team[6] ☐ Yes. Date completed:_____ ☐ No ☐ N/A
☐ (CCS) Patient Care Assessment ☐ Yes. Date completed:_____ ☐ No ☐ N/A
☐ (DDS) Regional Center Assessment ☐ Yes. Date completed:_____ ☐ No ☐ N/A
☐ (Pregnant/Postpartum) CPSP Assessment ☐ Yes. Date completed:_____ ☐ No ☐ N/A
☐ (Justice Involved) Re-entry Transition Plan ☐ Yes. Date completed:_____ ☐ 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 2. 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 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 ☐ Widowed ☐ Other:_____☐ Declined to answer	Relationship status of parent/guardian/caregiver: ☐ N/A ☐ Single ☐ Married ☐ Divorced ☐ Domestic partnership ☐ Widowed ☐ 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 ☐ 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 ☐ Completed college ☐ Technical school or training ☐ Other (list): ☐ N/A	
Parent/guardian/caregiver highest level of education: ☐ Elementary school ☐ Junior high school ☐ High school ☐Some college ☐ Completed college ☐ 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, please provide the 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
Name:
Relationship:
Contact information:

Section 3. 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 4. 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
If yes, please check all that apply:
☐ Asthma/chronic lung disease ☐ Cancer ☐ Cerebral palsy ☐ Cleft lip/palate ☐ Congenital heart defect
☐ Cystic fibrosis ☐ Pre-diabetes ☐ Diabetes Type 1 ☐ Diabetes Type 2
☐ HIV/AIDS ☐ Hypertension *(high blood pressure)* ☐ Kidney disease ☐ Muscular dystrophy
☐ Physical disability/para/quadriplegic/amputation ☐ Seizures/Epilepsy ☐ Sickle Cell Disease
☐ Spina bifida ☐ Organ Transplant (list): _____ ☐ Genetic condition(s) (list):_____
☐ Other conditions not listed above (list):

Does the C/Y member have trouble with vision? ☐ Yes ☐ No If yes, describe: _____
Glasses/contacts: ☐ Yes ☐ No ☐ Need
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
Please 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, please 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 an approximate date):

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

If applicable, document name/contact information for each additional provider/specialist:

Medications

Please tell me what medications the C/Y member is currently taking:

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

Please attach 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, please 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) (e.g., palliative care provider, meditation, therapies [list], medications, family/friend support)? Write in the space below if applicable.
☐ Yes ☐ No ☐ Declined to answer

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

Section 5. Pregnancy/Postpartum

Only complete if C/Y member is of child-bearing age. If not, skip to Section 6.

☐ Questions not reviewed for the C/Y member (child has not reached puberty/first menstrual period)
☐ Questions not reviewed for the C/Y member (other reason – indicate reason: _____)

Is the C/Y member currently pregnant? ☐ Yes ☐ No ☐ N/A ☐ 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, please 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 ☐ Unsure ☐ Declined to answer
Has the member selected a pediatrician for the baby? ☐ Yes ☐ No ☐ Declined to answer
If yes, please 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 comes home from the hospital (e.g. 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 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, please fill out the following information:
Name of doula:
Contact number:

Is the C/Y member working with a lactation consultant? ☐ Yes ☐ No ☐ Declined to answer
If yes, please fill out the following information:
Name of consultant:
Contact number:

Has the C/Y member had a postpartum appointment? ☐ Yes ☐ No ☐ Declined to answer
If yes, please fill out the date of the last appointment (if known): _____

Has the baby been going to their pediatrician for their appointments? ☐ Yes ☐ No ☐ Declined to answer

If yes, please fill out the following information:
Name of provider:
Contact number:
Office address:
Date of last visit (if known, or an approximate date):

Does the C/Y member need education/resources on post-pregnancy and infant health?
☐ Yes ☐ No ☐ Declined to answer

Section 6. Activities of Daily Living (ADLs)

The following are questions regarding the C/Y member's ability to perform basic self-care activities; complete questions only related to age of child/youth; skip other questions.

Does the C/Y member need help with any of these activities?	
If the C/Y member is age 0-5:	
Eating (as developmentally or age-appropriate – e.g., 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 – e.g., potty trained, dry through the night) ☐ Yes ☐ No ☐ N/A ☐ Declined to answer
If C/Y member is school-aged (6-18 years old):	
Bathing ☐ Yes ☐ No ☐ Declined to answer	Grooming (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 (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 Are you 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 you 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 7. 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, please fill out the following information:
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 ☐ Decline to answer

Over the past month (30 days), how many days has the C/Y member felt lonely? (Check 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 ☐ Decline 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 ages 11 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://www.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 8. 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**	**1-2 times**	**Monthly**	**Weekly**	**Daily**	**Date of Last Use**	**Is this substance use currently a problem for them?**
Alcohol	☐	☐	☐	☐	☐		☐ Yes ☐ No
Nicotine products (cigarette, 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	☐	☐	☐	☐	☐		☐ 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 9. 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, please fill out the following information:

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

If 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?

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

Does the member currently receive any treatment, supports or services related to this that are not identified elsewhere on this form (e.g., 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?

Educational opportunities and grants:

If the 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 Determinants 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? (check 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 (i.e. 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
The C/Y member lives with: ☐ Biological parent ☐ Adoptive parent ☐ Foster parent ☐ Guardian/conservator ☐ Caregiver 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 the C/Y member)? ☐ The C/Y member lives alone
Please highlight any other housing concerns that have not been identified above:
Environmental Safety
Is the C/Y member and/or parent/guardian/caregiver concerned 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		
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, please fill out the following information:

Name of provider:
Contact number:
Office address:
Date of last visit (if known, or an 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 the assessment:

Next Steps	Person Responsible
1.	
2.	
3.	
Next appointment/location:	