

ADHS-DBHS BEHAVIORAL HEALTH CLIENT COVER SHEET

Name _____ DOB _____ Client CIS ID# _____
Address _____ Client SS# _____
City _____ State _____ Zip _____ AHCCCS ID# _____
Phone _____ E-Mail _____ AHCCCS Health Plan _____
Gender: Male Female Primary/Preferred Language _____

Special Needs:

Interpreter No Yes, specify language _____
Mobility Assistance No Yes, identify assistance needed _____
Visual Impairment Assistance No Yes, identify assistance needed _____
Hearing Impairment Assistance No Yes, identify assistance needed _____
Need Childcare Arrangements No Yes, identify need _____

Key Contacts:

PCP/Physician: _____ Phone _____ Fax _____

PCP/Physician Address: _____

Legal Guardian: _____ Phone _____

Custody: Sole Joint Ward of Court (DES Legal Guardian) _____

Parent(s)/Step Parent(s) _____ Phone _____

_____ Phone _____

_____ Phone _____

Emergency Contact: _____ Phone _____

Address _____

Other Key Contacts (e.g., school, probation/parole officer, other involved agencies (CPS, DDD), neighbors, grandparents):

Name and Relationship to Person _____

Phone _____ Fax _____

Name and Relationship to Person _____

Phone _____ Fax _____

Name and Relationship to Person _____

Phone _____ Fax _____

Name and Relationship to Person _____

Phone _____ Fax _____

Insurance Coverage: Medicare Private (self-pay) TriCare Blue Cross HMO Other None

Insurance Co _____ Insurance ID #: _____ Policy No: _____

(Attach copy of insurance card)

Individual Completing Form and Title: _____ Date _____

**ADHS-DBHS BEHAVIORAL HEALTH ASSESSMENT: BIRTH – 5
AND SERVICE PLAN CHECKLIST**

Name _____ Date of Birth _____ Client CIS ID# _____

Accompanying Parent/Caregiver (note relationship to child): _____

Part A: Core Assessment (must be completed at this initial interview)

Pages 3 - 16

- | | |
|--|--|
| <ul style="list-style-type: none"> ▪ Reason for Assessment ▪ Child's Routines/Activities ▪ Developmental Issues ▪ Child's Medical History ▪ Risk Assessment | <ul style="list-style-type: none"> ▪ Family Information ▪ Observations and Reported Observations of the Child ▪ Observations of the Family-Child Interaction ▪ Clinical Formulation and Diagnoses ▪ Next Steps/Interim Service Plan |
|--|--|

Part B: Addenda (may be completed at subsequent appointment)

Pages 17 - 42

Indicate below, which of the addenda you as the assessor have completed on the child during this interview

Yes	To Be Completed Later	Not Applicable	Name of Addendum
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Culture and History Biological and Adoptive Families
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Family Culture and History Foster Families
<input type="checkbox"/>	<input type="checkbox"/>	-----	Developmental Checklist (or Ages and Stages Questionnaire) by age of child. (For all children, but if developmental issues are indicated at initial interview must be completed as part of Core Assessment.)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Behavioral Analysis (For children in which primary need identified is a behavioral issue(s).)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medical Care (For children who have been hospitalized, resided outside of home for medical reasons or have been treated for seizures.)
<input type="checkbox"/>	-----	<input type="checkbox"/>	Child Protective Services (Used for 24-hour urgent response for children removed by Child Protective Services.)

Part C: Behavioral Health Service Plan (may be completed at subsequent appointment)

Page 43

- Completed at initial interview Will be completed later

Part D: Annual Update and Review Summary

Pages 44 - 47

Assessor's Name (print) / Signature

Credentials/Position

Date

Behavioral Health Professional Reviewer Name (print) / Signature

Credentials/Position

Date

Agency

PART A: CORE ASSESSMENT: *BIRTH – 5*
(For children from birth until the day they turn 5)

REASON FOR ASSESSMENT

1. What concerns, needs or questions do you have regarding your child? What encouraged you to come in at this point in time? (Ask the parent/caregiver to describe the frequency, intensity and duration of symptoms, the circumstances in which they develop and continue to occur, the circumstances that improve or worsen them, etc.). _____

2. What effect have these difficulties had on your family? What effect have these difficulties had on others who are involved with your child or family? _____

3. What have you already tried that has helped, not made a difference, or made it worse? _____

4. Has your child received any previous evaluations or behavioral health services? Is your child currently receiving services from any other social service agency? _____

5. What is the most important thing that we can do for you today? _____

6. What outcomes would you like to see occur from the services we will provide? _____

CHILD’S ROUTINES/ACTIVITIES

1. How well does your child fall asleep, stay asleep, or wake up in the morning? _____

2. How well does your child eat? (Any difficulties or sensitivities to certain foods or food characteristics such as texture, smell, temperature? Any dietary restrictions? Any feeding or nursing problems with newborns?) _____

3. How well does your child adapt to new situations or changes in routines? How well does your child respond to your attempts to soothe or console him/her when something upsets him/her? _____

4. How does your child react to everyday experiences such as being bathed, having hair washed, wearing new clothes, being swung or lifted in the air, hearing loud sounds or being in noisy situations, seeing vivid colors or bright lights? (Does your child seem overly sensitive to any of these? Does your child seem to not respond to things that you would expect him/her to?) _____

5. Describe your child’s typical day. _____

DEVELOPMENTAL ISSUES

1. What do you consider most unique or special about your child. What do you most appreciate, enjoy or take pride in about your child? What talents, gifts or strengths do you believe your child displays? _____

DEVELOPMENTAL ISSUES (con't)

2. Are there things your child learns more quickly than other children of the same age or can do physically that others cannot?
 No Yes, if yes explain. _____

3. Are there things your child learns more slowly than other children of the same age or cannot do physically that others can? No
 Yes, if yes explain. _____

4. Do you have concerns about your child's body control (e.g., toilet training, sitting up, taking first steps, using words, feeding self)? No Yes, if yes explain. _____

5. Do you have concerns that your child may not be growing at a normal pace? No Yes, if yes explain _____

6. Is your child unable to keep up with other children the same age when they play together? No Yes, if yes explain. _____

7. Has your child ever been referred to, or received services through, the Division of Developmental Disabilities (DDD), Arizona Early Intervention Program (AZEIP) or Healthy Families or had an Individualized Education Plan (IEP)? No Yes, if yes explain. _____

Complete the Developmental Checklist or ASQ Addendum NOW if the responses to questions 3, 4, 5, 6 or 7 are YES.

If not, the Addendum can be completed at a follow up appointment.

CHILD'S MEDICAL HISTORY

1. How is your child's overall health today? (Do you consider him/her healthy?) _____

2. Does your child have any medical problems? Has he/she had any in the past? No Yes, if yes explain. Has your child had regular medical care? Yes No, if no explain. _____

3. Does your child have any allergies to medicines, foods or other things in the environment (dust, pets, certain plants or pollens, etc.)? No Yes, if yes explain. _____

4. Has your child had any head injuries or other injuries or illnesses that required a visit to a doctor, urgent care center or emergency room? No Yes, if yes explain. _____

5. Does your child take any prescription medication? No Yes, if yes explain. Any natural, herbal or alternative medicines or supplements? No Yes, if yes explain. Has your child required long term medications for any reason in the past? No Yes, if yes describe. _____

6. Has your child ever been hospitalized, or needed to reside outside the home to receive medical care? No Yes, if yes explain _____

7. Has your child been treated for seizures? No Yes, if yes explain. _____

Complete the Medical Addendum if the response to questions 6 or 7 is Yes.

RISK ASSESSMENT

1. Has your child ever been hurt physically, emotionally or sexually? Has your child ever been abused? No Yes, if yes explain. Is your child currently in danger? No Yes, if yes explain. _____

2. Has your child experienced neglect or deprivation of proper care-giving for any significant period? No Yes, if yes explain. Do you have any current concerns that your child is not well cared for? No Yes, if yes explain. _____

3. Has your child ever struck or intentionally harmed you or anyone else? No Yes, if yes explain. Do you or others feel unsafe around your child? No Yes, if yes explain. _____

4. Have you ever harmed your child, felt close to harming your child or been accused of harming your child? No Yes, if yes explain. _____

5. Has your child ever sexually acted out? No Yes, if yes explain. _____

6. Has your child ever witnessed violence between other people? No Yes, if yes explain.

ONLY complete the questions below, if the response is Yes to one or more of the above questions.

7. How do you believe the issues above have affected you and your child?

8. Do you believe any of these issues should be a focus of treatment at this time? No Yes, if yes explain.

RISK ASSESSMENT

9. Based on the responses above and your own observation, do you as the assessor believe:

a. There is an immediate safety risk for the child or for any others close to the child? No Yes, if yes explain.

b. The parent/caregiver appears to be at risk or has indications of the need for a crisis evaluation (observable symptoms, risk for withdrawal, malodorous, malnourished, dehydrated, etc)? No Yes, if yes explain.

Duty to Report: If you as the assessor believe that the child is or has been the victim of non-accidental physical injury, abuse, sexual abuse or deprivation, there is a duty to report to a peace officer or CPS (See A.R.S. 36-2881). If you are unclear about your duty to report, please consult with your supervisor.

If duty to report is warranted, explain the action taken.

FAMILY INFORMATION

1. Who lives at home all the time? Some of the time? Who else in the family lives nearby?

2. Who provides care for your child and who else is important as a source of support or an important influence on your child (include grandparents, extended family, day care providers, teachers, physicians, ministers/pastors or other persons providing spiritual support)?

3. Are there any current family stressors or situations that are affecting family functioning? No Yes, if yes explain.

OBSERVATIONS AND REPORTED OBSERVATIONS OF THE CHILD

Based on his/her observations and impressions of the child, the assessor should describe the child's:

1. Appearance.

2. General presentation:

a. 0-3 years of age (calm or fussy; clingy or detached; agitated or at ease; easy to soothe or hard to soothe; under reactive or over reactive to stimuli; content or crying; regressed or mature for age) **or**

b. 4-5 years of age (involved or detached; relaxed or anxious; playful or resistant to engaging; fearful or confident; labile or consistent).

3. Initial **reaction to changes** during the assessment process (presence of strangers, changes in activity, brief separations and reunions with parents/caregiver).

4. Ability to **self regulate** (reactions to external stimuli, atypical behaviors or movements, frustration tolerance).

5. **Speech** (quality and quantity, age appropriateness of speech or vocalizations, volume, rate).

OBSERVATIONS AND REPORTED OBSERVATIONS OF THE CHILD (con't)

6. **Motor activity and coordination:**

a. Muscle tone and mobility:

b. Gross coordination (infants: ability to push him/herself up, control head, sit or stand; toddlers: ability to walk, run, jump, hop, catch)

c. Fine motor coordination (infants: ability to grasp, throw, transfer from one hand to the other; toddlers: use of scissors, scribbling, catching)

d. Quality and quantity of activity (hyperactive, fidgety, restless, agitated, slowed)

7. **Thoughts** (fears, dreams or nightmares, preoccupations, disconnectedness, hallucinations).

8. **Mood and affect** (verbal and nonverbal communication; facial expression; range, intensity and duration of expressed emotion; responsiveness to situations, parents/caregivers).

9. **Relatedness** (to parents, to other family members, to examiner; describe level of physical contact, verbal and nonverbal expressions of affection).

10. **Play** (level of sophistication, themes, level of initiation with family members or clinician, responsiveness to the initiation of play by others).

11. Level of **consciousness** (alert, sedate, asleep).

OBSERVATIONS OF FAMILY-CHILD INTERACTIONS

Based on his/her observations and impressions of the family-child interaction, the assessor should describe:

1. How the family plays together.

2. The child's interactions with siblings.

3. The parents'/caregivers' level of affection for their child.

4. The parents'/caregivers' willingness to engage and interact with their child.

5. The appropriateness of the parents'/caregivers' response to their child's cues.

6. The parents'/caregivers' abilities to set limits for their child and to discipline.

OBSERVATIONS OF FAMILY-CHILD INTERACTIONS (con't)

7. The parents'/caregivers' ability to respond to and regulate their child's emotional responses (are they able to soothe?).

8. The parents'/caregivers' level of vigilance and protectiveness of their child

9. The quality of the parents'/caregivers' presentation of their child (How much do the parents/caregivers know about their child? What is their general attitude towards their child? What is their general attitude towards the assessor? How do they talk about their child?).

CLINICAL FORMULATION AND DIAGNOSES (con't)

3. **Axis III - Medical Conditions:** Identify the person's specific medical conditions and check the disease categories below that apply.

- Infectious and Parasitic Diseases (001-139):** abscesses, infections, tuberculosis, HIV/AIDS, pneumonia, blood infections, CMV, RSV
- Neoplasms (140-239):** cancer
- Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279):** diabetes, thyroid disorders, iron or vitamin deficiencies, immune deficiencies
- Diseases of the Blood and Blood-Forming Organs (280-289):** hemophilia, anemia
- Diseases of the Nervous System and Sense Organs (320-389):** blindness, deafness, loss of sensation, hypoxic encephalopathy, intraventricular hemorrhage, meningitis, hydrocephalus, seizures
- Diseases of the Circulatory System (390-459):** congenital heart defect, cardiomyopathy
- Diseases of the Respiratory System (460-519):** asthma, chronic lung disease, tracheomalacia
- Diseases of the Digestive System (520-579):** stomach disorders, ulcers, esophageal reflux (GERD), liver disease, pancreatic disease, pediatric under-nutrition, anomalies, feeding difficulties
- Diseases of the Genitourinary System (580-629):** bladder problems, kidney (renal) disorders or anomalies
- Complications of Pregnancy, Childbirth, and the Puerperium (630-676):** prematurity, intrauterine growth retardation, intrauterine drug or alcohol exposure, fetal alcohol syndrome
- Diseases of the Skin and Subcutaneous Tissue (680-709)**
- Diseases of the Musculoskeletal System and Connective Tissue (710-739):** orthopedic disorders, fractures/dislocations /deformities, cerebral palsy
- Congenital Anomalies (740-759):** genetic disorders, birth deformities
- Certain Conditions Originating in the Perinatal Period (760-779):** failure to thrive, colic, feeding problems
- Symptoms, Signs, and Ill-Defined Conditions (780-799):** retinopathy or prematurity, rickets, chronic otitis media (ear infections)
- Injury and Poisoning (800-999):** traumatic injuries, ingestions of poisonous/toxic substances

4. **Axis IV - Psychosocial or Environmental Stressors**

Problems with / related to:

- Primary Support Group
- Educational Problems
- Occupational Problems
- Marital Problems
- Housing Problems
- Interaction with Legal System
- Access to Health Care Services
- Family Problems
- Substance Use in Home
- Other _____

Significant recent losses:

- Death
- Injury
- Medical/Surgical
- Job
- Divorce/Separation
- Accident/Injury
- Child removed from home
- Violent Acts Against Person/Family
- Other _____

5. **Axis V –Children's Global Assessment Scale (CGAS) Score** (specific score not a range): _____ **

Scale	Children's Global Assessment Scale (CGAS) Children
100-91	Superior Functioning
90-81	Good Functioning in All Areas
80-71	No More Than Slight Impairment in Functioning
70-61	Some Difficulty in A Single Area, But Generally Functioning Pretty Well
60-51	Variable Functioning with Sporadic Difficulties or Symptoms in Several but Not All Social Areas
50-41	Moderate Degree of Interference in Functioning in Most Social Areas or Severe Impairment of Functioning in One Area
40-31	Major Impairment in Functioning in Several Areas and Unable to Function in One of These Areas
30-21	Unable to Function in Almost All Areas
20-11	Needs Considerable Supervision (above and beyond that which is age appropriate)
10-1	Needs Constant Supervision (above and beyond that which is age appropriate)

NEXT STEPS/INTERIM SERVICE PLAN

1. **Interim Service Plan.** Based on the child’s presenting issues, your impressions and the preferences of the child and his/her parents/caregivers, describe in the Interim Service Plan below recommended next steps (e.g., formation of a Team*, response to immediate risks and needs of the child, further assessment, appropriate referrals). Additionally, this Interim Service Plan should include:

- Referral to the child’s primary care physician, if *physical health problems* have been identified or if the child has not had regular well-child EPSDT visits.
- Referral of any child under the age of 3 to AzEIP, if triggered by *the Developmental Checklist Addendum*.
- Additional considerations for urgent response for children removed by Child Protective Services**

The assessor may also add a goal statement, if appropriate.

*If an AzEIP IFSP team has been formed for the child, the Clinical Liaison will coordinate CFT functions with IFSP functions so as to avoid duplicative processes between systems and to ensure consistency and compatibility of service plans.

For urgent response for **children removed by Child Protective Services, the assessor must include as part of the recommended next steps/interim service plan, identification of:

1. Actions needed to be taken immediately to mitigate the effects of the removal itself;
2. Supports and services the child’s caregivers may need to meet the child’s needs; and
3. A plan to ensure that even asymptomatic children are reassessed and observed for surfacing behavioral health needs within at least the next 23 days (or sooner if indicated).

The assessor may also provide any input he/she has regarding the types and amount/frequency of contact (e.g., visits, phone calls, e-mail), the child should have with parents, siblings, relatives and other individuals important to the child.

<u>Description of Next Steps (Action) to Be Taken</u>	<u>Who Will Be Responsible to Ensure Action Occurs</u>	<u>Where Action/Step Will Take Place (e.g., provider)</u>	<u>When Action/ Step Will Take Place</u>

NEXT STEPS/INTERIM SERVICE PLAN (con't)

2. Identify any immediate next steps to be taken by the parent/caregiver (including how these next steps will be accomplished and where and when these steps will be taken):

3. Identify specific people who may be supportive and helpful and who should be invited to be part of the child’s Child and Family Team (or AzEIP Team), including phone numbers and action to be taken:

4. Identify any additional documentation (e.g., medical records, IEP), which needs to be collected to assist in the ongoing assessment and service planning including the individuals and/or agencies and action to be taken to obtain this information:

5. Identify who the parent/caregiver should contact if their child needs immediate assistance before the next appointment:

Parent/Caregiver Signature/Guardian

Date

Assessor’s Name (print) / Signature

Credentials/Position

Date

Behavioral Health Professional Reviewer Name (print) / Signature

Credentials/Position

Date

Agency

Note: The assessor should make sure to provide the parent/caregiver with a copy of the interim service plan. The CPS specialist, however, should receive a copy of the entire next steps/ interim service plan section.

PART B: ADDITIONAL ADDENDA: BIRTH – 5

**FAMILY CULTURE AND HISTORY
(BIOLOGICAL AND ADOPTIVE FAMILIES)** If addendum completed at follow-up appointment, assessor should sign _____ and date _____

1. What are the things that make your family members feel good about themselves and help make your lives meaningful (include interests, strengths, talents, skills and abilities, knowledge/education, friends, extended family, values, religion/spirituality, culture/community, work, school, etc.)?

2. Is there anything that your family describes about itself or its cultural background that would help the assessor understand you better or how people respond to you? How does your cultural background influence you or the people who are most important to you?

3. Describe your family’s support system (the individuals with whom you are most comfortable, to whom do you turn for help, with whom do you feel most comfortable when talking about important matters?).

4. Who in the family does your child remind you of the most, and what is each parent’s response to that person?

5. Has your child ever experienced any situations where he/she had multiple or inconsistent caregivers? No Yes, if yes explain.

6. Have you used the services of any daycare? No Yes Has your child been in a nursery or pre-school? No Yes

**FAMILY CULTURE AND HISTORY
(BIOLOGICAL AND ADOPTIVE FAMILIES) (con't)**

11. Describe the medical and mental health/substance abuse history of each parent, including current and past problems, evaluations or services.

12. Describe the history of the parents' relationship with each other (how long have they known each other, how well do they get along, have there been any separations or divorce)?

13. Any history of arrests or current legal involvement? No Yes, if yes explain.

14. Describe the medical and mental health/substance abuse history of grandparents, including current and past problems, evaluations or services.

15. Any history of arrests or current legal involvement in grandparents' history? No Yes, if yes explain.

For Biological Families only:

16. What effect did the pregnancy have on each parent, their relationship with each other and with other family members?

**FAMILY CULTURE AND HISTORY
(BIOLOGICAL AND ADOPTIVE FAMILIES) (con't)**

17. Did the pregnancy create any additional stresses on either parent or other family members?

18. What changed for each parent when they became aware of the pregnancy (e.g., work, schedule, lifestyle, attitudes)?

For Adoptive Families only:

19. What do you know about the pregnancy, delivery, and early life experiences of the child?

20. Does the child remember the biological parents/family? Does the child ask for or inquire about them?

If addendum completed at follow-up appointment, assessor should sign _____ and date _____

**FAMILY CULTURE AND HISTORY
(FOSTER FAMILIES)**

1. What are the things that make your family members feel good about themselves and help make your lives meaningful (include interests, strengths, talents, skills and abilities, knowledge/education, friends, extended family, values, religion/spirituality, culture/community, work, school, etc.)?

2. Is there anything that your family describes about itself or its cultural background that would help the assessor understand you better or how people respond to you? How does your cultural background influence you or the people who are most important to you?

3. Describe your family’s support system (the individuals with whom you are most comfortable, to whom do you turn for help, with whom do you feel most comfortable when talking about important matters?).

4. Has your child ever experienced any situations where he/she had multiple or inconsistent caregivers? No Yes, if yes explain.

5. Have you used the services of any daycare? No Yes Has the child been in a nursery or pre-school? No Yes

6. How long has the child been in your home?

7. How many previous placements have there been and what for what lengths of time?

8. How have the relationships between your family and the child developed?

9. What was the child like when he/she first arrived?

10. How would you describe the child now?

**FAMILY CULTURE AND HISTORY
(FOSTER FAMILIES) (con;t)**

11. What effect did the child’s entry into your home have on others in the family?

12. What do you know about the pregnancy, delivery, and early life experiences of the child?

13. Does the child remember the biological parents/family? Does the child ask for or inquire about them?

14. Describe the important events in the personal history of each foster parent (e.g., deaths, separations from a parent or sibling, their parent’s separation or divorce, physical or sexual abuse or exposure to violence).

15. Describe each foster parent’s experience of being raised in his/her own family (who raised them, who had the most influence, who is their positive and negative model for how to parent their own child?).

DEVELOPMENTAL CHECKLIST²If addendum completed at follow-up appointment, assessor should sign
_____ and date _____**(Must be completed at initial visit if developmental concerns are identified on the Developmental Issues Section)
The Ages and Stages Questionnaire may be used as an alternative to the Developmental Checklist.****I. ONE TO THREE MONTHS****A. Developmental Checklist**Movement**Yes** **No**

- | | | |
|---|--------------------------|--------------------------|
| Raises head and cheek when lying on stomach (3 mos.) | <input type="checkbox"/> | <input type="checkbox"/> |
| Supports upper body with arms when lying on stomach (3 mos.) | <input type="checkbox"/> | <input type="checkbox"/> |
| Stretches legs out when lying on stomach or back (2-3 mos.) | <input type="checkbox"/> | <input type="checkbox"/> |
| Opens and shuts hands (2-3 mos.) | <input type="checkbox"/> | <input type="checkbox"/> |
| Pushes down on his legs when feet are placed on firm surface (3 mos.) | <input type="checkbox"/> | <input type="checkbox"/> |

Visual

- | | | |
|---|--------------------------|--------------------------|
| Watches face intently (2-3 mos.) | <input type="checkbox"/> | <input type="checkbox"/> |
| Follows moving objects (2 mos.) | <input type="checkbox"/> | <input type="checkbox"/> |
| Recognizes familiar objects and people at a distance (3 mos.) | <input type="checkbox"/> | <input type="checkbox"/> |
| Starts using hands and eyes in coordination (3 mos.) | <input type="checkbox"/> | <input type="checkbox"/> |

Hearing and Speech

- | | | |
|--|--------------------------|--------------------------|
| Smiles at the sound of voice (2-3 mos.) | <input type="checkbox"/> | <input type="checkbox"/> |
| Cooing noises; vocal play begins at 3 mos. | <input type="checkbox"/> | <input type="checkbox"/> |
| Attends to sound (1-3 mos.) | <input type="checkbox"/> | <input type="checkbox"/> |
| Startles to loud noise (1-3 mos.) | <input type="checkbox"/> | <input type="checkbox"/> |

Social and Emotional

- | | | |
|--|--------------------------|--------------------------|
| Begins to develop a social smile (1-3 mos.) | <input type="checkbox"/> | <input type="checkbox"/> |
| Enjoys playing with other people and may cry when playing stops (2-3 mos.) | <input type="checkbox"/> | <input type="checkbox"/> |
| Becomes more communicative and expressive with face and body (2-3 mos.) | <input type="checkbox"/> | <input type="checkbox"/> |
| Imitates some movements and facial expressions | <input type="checkbox"/> | <input type="checkbox"/> |

² With permission of the authors, this checklist is based on a checklist adapted by First Look and The Early Childhood Direction Center from Shelov, S.P. & Hannenmann, R.E. (1994). The American Academy of Pediatrics: Caring for Your Baby and Young Child Birth to Age 5: The Complete and Authoritative Guide. New York: Bantam Doubleday Dell Pub.

DEVELOPMENTAL CHECKLIST³

If addendum completed at follow-up appointment, assessor should sign

(Must be completed *at initial visit* if developmental concerns are identified on the Developmental Issues Section)

The Ages and Stages Questionnaire may be used as an alternative to the Developmental Checklist.

II. FOUR TO SEVEN MONTHS**A. Developmental Checklist**Movement

	<u>Yes</u>	<u>No</u>
Pushes up on extended arms (5 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Pulls to sitting with no head lag (5 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Sits with support of hands (5-6 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Sits unsupported for short periods (6-8 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Supports his/her whole weight on legs (6-7 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Grasps feet (6 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Transfers objects from hand to hand (6-7 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Uses raking grasp (not pincer) (6 mos.)	<input type="checkbox"/>	<input type="checkbox"/>

Visual

Looks for toy beyond tracking range (5-6 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Tracks moving objects with ease (4-7 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Grasps objects dangling in front of him/her (5-6 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Looks for fallen toys (5-7 mos.)	<input type="checkbox"/>	<input type="checkbox"/>

Language

Distinguishes emotions by tone of voice (4-7 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Responds to sound by making sounds (4-6 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Uses voice to express joy and displeasure (4-6 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Syllable repetition begins (5-7 mos.)	<input type="checkbox"/>	<input type="checkbox"/>

Cognitive

Finds partially hidden objects (6-7 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Explores with hands and mouth (4-7 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Struggles to get objects that are out of reach (5-7 mos.)	<input type="checkbox"/>	<input type="checkbox"/>

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DEVELOPMENTAL CHECKLIST⁴If addendum completed at follow-up appointment, assessor should sign
_____ and date _____**(Must be completed at initial visit if developmental concerns are identified on the Developmental Issues Section)
The Ages and Stages Questionnaire may be used as an alternative to the Developmental Checklist.****III. EIGHT TO TWELVE MONTHS****A. Developmental Checklist**

<u>Movement</u>	<u>Yes</u>	<u>No</u>
Gets to sitting position without assistance (8-10 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Crawls forward on belly	<input type="checkbox"/>	<input type="checkbox"/>
Assumes hand and knee position	<input type="checkbox"/>	<input type="checkbox"/>
Creeps on hands and knees	<input type="checkbox"/>	<input type="checkbox"/>
Gets from sitting to crawling or prone (lying on stomach) position (10-12 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Pulls self up to standing position	<input type="checkbox"/>	<input type="checkbox"/>
Walks holding onto furniture	<input type="checkbox"/>	<input type="checkbox"/>
Stands momentarily without support	<input type="checkbox"/>	<input type="checkbox"/>
May walk two or three steps without support	<input type="checkbox"/>	<input type="checkbox"/>
 <u>Hand and Finger Skills</u>		
Uses pincer grasp (7-10 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Bangs two cubes together	<input type="checkbox"/>	<input type="checkbox"/>
Puts objects into container (10-12 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Takes objects out of container (10-12 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Pokes with index finger	<input type="checkbox"/>	<input type="checkbox"/>
Tries to imitate scribbling	<input type="checkbox"/>	<input type="checkbox"/>
 <u>Cognitive</u>		
Explores objects in many different ways; shaking, banging, throwing, dropping (8-10 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Finds hidden objects easily (10-12 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Looks at correct picture when image is named	<input type="checkbox"/>	<input type="checkbox"/>
Imitates gestures (9-12 mos.)	<input type="checkbox"/>	<input type="checkbox"/>

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DEVELOPMENTAL CHECKLIST: 8-12 MONTHS. (con't)

Language

Yes **No**

- Responds to simple verbal requests
- Responds to “no”
- Makes simple gestures such as shaking head for no (8-12 mos.)
- Babbles with inflection (8-10 mos.)
- Babbles “dada” and “mama” (8-10 mos.)
- Babbles “dada” and “mama” for specific person (11-12 mos.)
- Uses exclamations such as “oh-oh”

Social and Emotional

- Shy or anxious with strangers (8-12 mos.)
- Cries when mother or father leaves (8-12 mos.)
- Enjoys imitating people in play (10-12 mos.)

Social and Emotional (continued)

- Shows specific preferences for certain people and toys (8-12 mos.)
- Prefers mother and/or regular care provider over all others (8-12 mos.)
- Repeats sounds or gestures for attention (10-12 mos.)
- Finger-feeds him/herself (8-12 mos.)
- Extends arm or leg to help when being dressed

B. Developmental Red Flags*

- Does not crawl
- Drags one side of body while crawling (for over one month)
- Cannot stand when supported
- Does not search for objects that are hidden (10-12 mos.)
- Does not say single words (“mama” or “dada”)
- Does not learn to use gestures such as waving or shaking head
- Does not sit steadily by 10 mos.
- Does not show interest in “peek-a-boo” or “patty cake” by 8 mos.
- Does not babble by 8 mos.
- Does not babble by 8 mos. (“dada”, “baba”, “mama”)

Comments:

*Please note that any “Red Flags” identified should trigger a referral to the child’s PCP as well as a referral to AzEIP.

DEVELOPMENTAL CHECKLIST⁵

If addendum completed at follow-up appointment, assessor should sign

_____ and date _____

(Must be completed *at initial visit* if developmental concerns are identified on the Developmental Issues Section)

The Ages and Stages Questionnaire may be used as an alternative to the Developmental Checklist.

IV. TWELVE TO TWENTY-FOUR MONTHS**A. Developmental Checklist**Movement

	<u>Yes</u>	<u>No</u>
Walks alone (12-16mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Pulls toys behind while walking (13-16 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Carries large toy or several toys while walking (12-15 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Begins to run stiffly (16-18 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Walks into ball (18-24 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Climbs onto and down from furniture unsupported (16-24 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Walks up and down stairs holding on to support (18-24 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Stands momentarily without support	<input type="checkbox"/>	<input type="checkbox"/>

Hand and Finger Skills

Scribbles spontaneously (14-16 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Turns over container to pour out contents (12-18 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Building tower of 4 blocks, or more (20-24 mos.)	<input type="checkbox"/>	<input type="checkbox"/>

Language

Points to object or picture when it's named for him/her (18-24 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Recognizes names or familiar people, objects, and body parts (18-24 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Says several single words (15-18 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Uses two word sentences (14-18 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Follows simple one-step instructions (14-18 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Repeats words overheard in conversations (16-18 mos.)	<input type="checkbox"/>	<input type="checkbox"/>

Cognitive

Finds objects even when hidden under 2 or 3 covers	<input type="checkbox"/>	<input type="checkbox"/>
Begins to sort shapes and colors (20-24 mos.)	<input type="checkbox"/>	<input type="checkbox"/>

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DEVELOPMENTAL CHECKLIST⁶

If addendum completed at follow-up appointment, assessor should sign _____ and date _____

(Must be completed *at initial visit* if developmental concerns are identified on the Developmental Issues Section)
 The Ages and Stages Questionnaire may be used as an alternative to the Developmental Checklist.

V. TWENTY-FOUR TO THIRTY-SIX MONTHS**A. Developmental Checklist**Movement

	<u>Yes</u>	<u>No</u>
Climbs well (24-30 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Walks down stairs alone, placing both feet on each step (26-28 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Walks up stairs alternating feet with support (24-30 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Swings leg to kick ball (24-30 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Runs easily (24-26 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Pedals tricycle (30-36 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Bends over easily without falling (24-30 mos.)	<input type="checkbox"/>	<input type="checkbox"/>

Hand and Finger Skills

Makes vertical, horizontal, circular strokes with pencil or crayon (30-36 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Turns book pages one at a time (24-30 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Builds a tower of more than 6 blocks (24-30 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Holds a pencil in writing position (30-36 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Screws and unscrews jar lids, nuts and bolts (24-30 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Turns rotating handles (24-30 mos.)	<input type="checkbox"/>	<input type="checkbox"/>

Language

Recognizes and identifies almost all common objects and pictures (26-32 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Understands most sentences (24-40 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Understands physical relationship, e.g., on, in, under (30-36 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Can say name, age, and sex (30-36 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Uses pronoun, e.g., you, me, we, they (24-30 mos.)	<input type="checkbox"/>	<input type="checkbox"/>
Strangers can understand most of his/her words (30-36 mos.)	<input type="checkbox"/>	<input type="checkbox"/>

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DEVELOPMENTAL CHECKLIST⁷(Must be completed *at initial visit* if developmental concerns are identified on the Developmental Issues Section)

The Ages and Stages Questionnaire may be used as an alternative to the Developmental Checklist.

If addendum completed at follow-up appointment, assessor should sign _____ and date _____

VI. THREE TO FOUR YEARS**A. Developmental Checklist**Movement

	<u>Yes</u>	<u>No</u>
Hops and stands on one foot up to 5 seconds	<input type="checkbox"/>	<input type="checkbox"/>
Goes upstairs and downstairs without support	<input type="checkbox"/>	<input type="checkbox"/>
Kicks ball forward	<input type="checkbox"/>	<input type="checkbox"/>
Throws ball overhand	<input type="checkbox"/>	<input type="checkbox"/>
Catches bounced ball most of the time	<input type="checkbox"/>	<input type="checkbox"/>
Moves forward and backward	<input type="checkbox"/>	<input type="checkbox"/>
Uses riding toys	<input type="checkbox"/>	<input type="checkbox"/>

Hand and Finger Skills (by the **end** of age 3)

Copies square shapes	<input type="checkbox"/>	<input type="checkbox"/>
Draws a person with 2 to 4 body parts	<input type="checkbox"/>	<input type="checkbox"/>
Uses scissors	<input type="checkbox"/>	<input type="checkbox"/>
Draws circles and squares	<input type="checkbox"/>	<input type="checkbox"/>
Begins to copy some capital letters	<input type="checkbox"/>	<input type="checkbox"/>
Can feed self with spoon	<input type="checkbox"/>	<input type="checkbox"/>

Language (by the **end** of age 3)

Understands the concepts of “same” and “different”	<input type="checkbox"/>	<input type="checkbox"/>
Has mastered some basic rules of grammar	<input type="checkbox"/>	<input type="checkbox"/>
Speaks in sentences of 5 to 6 words	<input type="checkbox"/>	<input type="checkbox"/>
Asks questions	<input type="checkbox"/>	<input type="checkbox"/>
Speaks clearly enough for strangers to understand	<input type="checkbox"/>	<input type="checkbox"/>
Tells stories	<input type="checkbox"/>	<input type="checkbox"/>

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DEVELOPMENTAL CHECKLIST: 3-4 YEARS. (con't)

Cognitive (by the end of age 3)

	<u>Yes</u>	<u>No</u>
Correctly names some colors	<input type="checkbox"/>	<input type="checkbox"/>
Understands the concept of counting and may know a few numbers	<input type="checkbox"/>	<input type="checkbox"/>
Begins to have a clearer sense of time	<input type="checkbox"/>	<input type="checkbox"/>
Follows three-part commands	<input type="checkbox"/>	<input type="checkbox"/>
Recalls parts of a story	<input type="checkbox"/>	<input type="checkbox"/>
Understands the concept of same/different	<input type="checkbox"/>	<input type="checkbox"/>
Engages in fantasy play	<input type="checkbox"/>	<input type="checkbox"/>
Understands causality (“I can make things happen”)	<input type="checkbox"/>	<input type="checkbox"/>

Social and Emotional (by the end of age 3)

Interested in new experiences	<input type="checkbox"/>	<input type="checkbox"/>
Cooperates/plays with other children	<input type="checkbox"/>	<input type="checkbox"/>
Plays “mom” or “dad”	<input type="checkbox"/>	<input type="checkbox"/>
More inventive in fantasy play	<input type="checkbox"/>	<input type="checkbox"/>
Dresses and undresses	<input type="checkbox"/>	<input type="checkbox"/>
More independent	<input type="checkbox"/>	<input type="checkbox"/>
Often cannot distinguish between fantasy and reality	<input type="checkbox"/>	<input type="checkbox"/>
May have imaginary friends or see monsters	<input type="checkbox"/>	<input type="checkbox"/>

B. Developmental Red Flags*

- | | |
|---|--|
| <ul style="list-style-type: none"> ▪ Cannot jump in place ▪ Cannot ride a trike ▪ Cannot grasp a crayon between thumb and fingers ▪ Has difficulty scribbling ▪ Cannot copy a circle ▪ Cannot stack four blocks ▪ Still clings or cries when parents leave him ▪ Shows no interest in interactive games | <ul style="list-style-type: none"> ▪ Ignores other children ▪ Does not respond to people outside the family ▪ Does not engage in fantasy play ▪ Resists dressing, sleeping, using the toilet ▪ Lashes out without any self-control when angry or upset ▪ Does not use sentences of more than three words ▪ Does not use “me” or “you” appropriately |
|---|--|

Comments:

*Please note that any “Red Flags” identified should trigger a referral to the child’s PCP and any symptoms that suggest likely difficulties learning should trigger a referral to the school for an evaluation.

DEVELOPMENTAL CHECKLIST⁸(Must be completed *at initial visit* if developmental concerns are identified on the Developmental Issues Section)

The Ages and Stages Questionnaire may be used as an alternative to the Developmental Checklist.

If addendum completed at follow-up appointment, assessor should sign _____ and date _____

VII. FOUR TO FIVE YEARS**A. Developmental Checklist**Movement

	<u>Yes</u>	<u>No</u>
Stands on one foot for 10 seconds or longer	<input type="checkbox"/>	<input type="checkbox"/>
Hops, somersaults	<input type="checkbox"/>	<input type="checkbox"/>
Swings, climbs	<input type="checkbox"/>	<input type="checkbox"/>
May be able to skip	<input type="checkbox"/>	<input type="checkbox"/>

Hand and Finger Skills (by the **end** of age 4)

Copies triangle and other geometric patterns	<input type="checkbox"/>	<input type="checkbox"/>
Draws person with body	<input type="checkbox"/>	<input type="checkbox"/>
Prints some letters	<input type="checkbox"/>	<input type="checkbox"/>
Dresses and undresses without assistance	<input type="checkbox"/>	<input type="checkbox"/>
Uses fork, spoon	<input type="checkbox"/>	<input type="checkbox"/>
Usually cares for own toilet needs	<input type="checkbox"/>	<input type="checkbox"/>

Language (by the **end** of age 4)

Recalls parts of a story	<input type="checkbox"/>	<input type="checkbox"/>
Speaks sentences of more than 5 words	<input type="checkbox"/>	<input type="checkbox"/>
Uses future tense	<input type="checkbox"/>	<input type="checkbox"/>
Tells longer stories	<input type="checkbox"/>	<input type="checkbox"/>
Says name and address	<input type="checkbox"/>	<input type="checkbox"/>

Cognitive (by the **end** of age 4)

Can count 10 or more objects	<input type="checkbox"/>	<input type="checkbox"/>
Correctly names at least 4 colors	<input type="checkbox"/>	<input type="checkbox"/>
Better understands the concept of time	<input type="checkbox"/>	<input type="checkbox"/>
Knows about things used every day in the home (money, food, etc.)	<input type="checkbox"/>	<input type="checkbox"/>

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BEHAVIORAL ANALYSIS	If addendum completed at follow-up appointment, assessor should sign _____ and date _____
(For children in which primary need identified is related to the child’s behavior)	

A. Descriptive Analysis of the Child’s Behavior.

1. Describe the behavior of concern by general type (e.g., aggressive, self injurious, oppositional), then in specific terms (e.g., biting, refusing to eat, screaming). *This should be listed as one of the needs and objectives in the Service Plan.*

2. When did the behavior first start? Were there any significant events or changes in your child’s life, family or routine about this same time?

3. Describe the duration of the behavior (e.g., minutes, hours, days).

4. Describe the frequency of the behavior (e.g., every hour, three times a day, once a week).

5. Describe where the behavior occurs (e.g., everywhere, only at home, only in the car).

6. Identify in whose presence the behavior occurs (e.g., everyone, only mother, anyone except grandmother).

7. Does this behavior bother everyone involved with the child equally, or does it bother some more than others?

8. Describe when the behavior occurs (e.g., all day, bedtime, when hungry, when left alone, when ill or fatigued).

9. Describe any activities that are associated with the behavior (e.g., feeding child, arguing with someone, picking up child).

10. What do you (or other parent/caregiver) usually do to prevent the behavior, and how effective is this?

BEHAVIORAL ANALYSIS (con't)

11. What is usually your (or other parent/caregiver) immediate reaction to the behavior?

12. What do you (or other parent/caregiver) usually do as a consequence to the behavior, and how effective is this?

13. Is the behavior worse, better or different if routines are followed or disrupted?

B. Need/Intention Analysis

1. What do you believe is the reason for the behavior or the cause of the behavior?

2. Describe any additional or different possible needs or intentions behind the behavior that you as the assessor see.

3. If certain needs or intentions are believed to be driving the behavior, describe how often and how well you believe these needs are being met?

4. How do you believe that these needs or intentions should be handled given your preferences, cultural background, beliefs, etc.?

MEDICAL CARE

If addendum completed at follow-up appointment, assessor should sign _____ and date _____

(For children, who have been hospitalized, resided outside of home for medical reasons or have been treated for seizures)

A. If your child has a history of seizures, answer the following questions:

1. What kind of seizures has your child had?

2. When was the diagnosis made?

3. Did you notice any behavioral changes after your child began to have seizures?

4. Who currently is providing treatment for your child?

5. What kind of treatment is being provided (meds, alternative therapies)?

6. Is your child still having seizures? If so, how often? How long do they last? How frequently to they occur?

B. For **each** instance that your child was hospitalized or placed in out of home care for a medical condition, answer the following questions.

- Why did your child require such services (surgery, rehab, etc.)?
- Where was your child placed?
- How long did your child remain outside the home?
- What kind of services did your child receive?
- Did you notice any significant behavioral changes as a result of the placement?

CHILD PROTECTIVE SERVICES

(For 24-hour urgent response for children removed by Child Protective Services)

The questions contained in this addendum are primarily intended to be responded to by the Child Protective Service specialist involved with the child’s case. In addition to this addendum, the assessor should complete the Behavioral Health Client Sheet, the Client Demographic Information Sheet and the following sections in the Core Assessment: Risk Assessment, Observations and Reported Observations of the Child (and if possible, Observations of the Family-Child Interaction), Diagnostic Summary and the Next Steps/Interim Service Plan. The remainder of the Core Assessment should only be completed at this time if the child’s clinical condition/circumstances allow. The assessor should make sure that the Child Protective Service Specialist’s name and phone number is recorded on the Cover Sheet.

- 1. What are the reasons for the removal of the child from the parent /guardian? Are there other siblings in the family and/or living in the same home? Are other siblings victims of abuse and has CPS removed them? Explain.

- 2. Has the child had prior involvement with Child Protective Services? No Yes, if yes explain.

- 3. What is the child’s perception of his/her parents, siblings, and/or family? What is the child’s perception of his/her relationship with his/her parents/siblings/family? What are the child’s feelings, sense of attachment, trust, security, love and affection toward his/her parents/guardian?

- 4. Was the child or the family receiving behavioral health services prior to the removal from the parent/guardian’s home? No Yes, if yes explain.

CHILD PROTECTIVE SERVICES (con't)
(For 24-hour urgent response for children removed by Child Protective Services)

For Questions 5 through 9 the assessor should check below those statements which best describe the child based on the assessor's observations and discussion with the Child Protective Service specialist at the time of the interview.

5. General presentation for children 0-3 years of age:

- | | |
|---|---|
| <input type="checkbox"/> Crying | <input type="checkbox"/> Disengaged |
| <input type="checkbox"/> Clingy | <input type="checkbox"/> Head-banging |
| <input type="checkbox"/> Hard to soothe | <input type="checkbox"/> Calm |
| <input type="checkbox"/> Regressed | <input type="checkbox"/> Easy to soothe |
| <input type="checkbox"/> Tantruming | |

6. General presentation for children 4 years of age or older:

- | | | |
|--|---|---|
| <input type="checkbox"/> Listless, withdrawn | <input type="checkbox"/> Labile | <input type="checkbox"/> Violent, homicidal |
| <input type="checkbox"/> Disinterested | <input type="checkbox"/> Fussy | <input type="checkbox"/> Suicidal |
| <input type="checkbox"/> Anxious | <input type="checkbox"/> Shocked | <input type="checkbox"/> Relaxed |
| <input type="checkbox"/> Fearful | <input type="checkbox"/> Sad | <input type="checkbox"/> Euthymic |
| <input type="checkbox"/> Angry | <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Attentive |

7. Understanding of removal process:

- Confused
- Self Blaming
- Realistic
- Distorted
- Age appropriate
- No understanding
- No age appropriate understanding

9. Understanding of placement options:

- Good
- Poor
- No age appropriate understanding

8. Sense of future

- Hopeful
- Realistic
- Unrealistically Optimistic
- Pessimistic
- Empowered
- Planning own destiny
- Unable to perceive a future
- No age appropriate understanding

10. Describe the child's way of coping with the removal (e.g., blaming others, in denial, developing physical symptoms, regressing in behavior, accepting).

11. What do you or the child feel will be helpful in soothing the child, providing immediate comfort or mitigating the trauma of the removal (e.g., special foods, transitional object, parental visits, maintenance in current school, contact with friends, church attendance.)?

PART C: BEHAVIORAL HEALTH SERVICE PLAN: BIRTH – 5

Name: _____ CIS Client ID# _____ Program: _____ Today's Date: _____
 Individuals at Service Planning Meeting: _____

RECOVERY GOAL/CHILD-FAMILY VISION:

CHILD'S STRENGTHS:

Review Date (Objective Target Date): _____

IDENTIFIED NEEDS and SPECIFIC OBJECTIVES (to address these needs)	Current Measure	INTERVENTIONS to MEET OBJECTIVES		Desired Measure	Achieved Measure (at target date)	Measure Met (Y/N)
		Specific Services and Frequency	Strengths Used			
1						
2						
3						

DISCHARGE PLAN (add discharge date if known):

Parent/Caregiver _____ Date: _____

Yes, I am in agreement with the types and levels of services included in my service plan. No, I disagree with the types and/or levels of some or all of the services included in my service plan. By checking this box, I will 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. *

Clinical Liaison _____ Date: _____ Other _____ Date: _____

BH Prof. Rev. _____ Date: _____ Other _____ Date: _____

**PART D: ANNUAL BEHAVIORAL HEALTH UPDATE AND
REVIEW SUMMARY: *BIRTH – 5***

Name _____ Date of Birth _____ Client CIS ID# _____

Accompanying Family Member/Significant Other (Note relationship to person): _____

Date of Current Assessment/Review _____ Date of Initial Assessment/Last Review _____

I. STATUS REVIEW

1. **Emotional:** List all therapeutic interventions/services/supports utilized over the past year (if medications are being used, include in question 2). What helped? What did not help or made the condition worse? What has been the overall functioning over time since the last assessment? What is the current status?

2. **Medical:** describe all medications tried and symptomatic response to treatment; significant medication side effects/adverse drug reactions, AIMS tests; significant changes in medical condition and hospitalizations; physical development

List all currently prescribed medications and dosages, including medications prescribed for other physical/medical conditions:

<u>Medication</u>	<u>Dosage/Frequency</u>	<u>Purpose</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. **Environmental:** List all significant events/trauma since the last assessment/review, placements outside the home; family's cultural preferences/ considerations for service provision.

4. **Progress:** Describe child's progress in reaching treatment objectives (Consider functioning related to the following areas as appropriate: living environment; activities of daily living; school preparation; interpersonal relationships; developmental progress).

5. **Risk Factors:** Describe any significant long-term chronic risk factors such as harm to self or others; exposure to drug use; personal drug use; nutrition; exploitation, abuse, or neglect.

**PART D: ANNUAL BEHAVIORAL HEALTH UPDATE AND
REVIEW SUMMARY: BIRTH – 5**

II. CURRENT DIAGNOSIS

1. Axis I.	<u>DSM-IV TR Code</u>	<u>Diagnosis</u>	<u>Justification for diagnoses (es)</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. Axis II.	<u>DSM-IV TR Code</u>	<u>Diagnosis</u>	<u>Justification for diagnosis (es)</u>
_____	_____	_____	_____
_____	_____	_____	_____

3. Axis III. Identify the child’s specific medical conditions and check below the disease categories that apply.

- | | |
|--|---|
| <input type="checkbox"/> Infectious and Parasitic Diseases (001-139)
<input type="checkbox"/> Neoplasms (140-239)
<input type="checkbox"/> Endocrine, Nutritional, and Metabolic Diseases and Immunity Disorders (240-279)
<input type="checkbox"/> Diseases of the Blood and Blood-Forming Organs (280-289)
<input type="checkbox"/> Diseases of the Nervous System and Sense Organs (320-389)
<input type="checkbox"/> Diseases of the Circulatory System (390-459)
<input type="checkbox"/> Diseases of the Respiratory System (460-519)
<input type="checkbox"/> Diseases of the Digestive System (520-579) | <input type="checkbox"/> Diseases of the Genitourinary System (580-629)
<input type="checkbox"/> Complications of Pregnancy, Childbirth, Puerperium (630-676)
<input type="checkbox"/> Diseases of the Skin and Subcutaneous Tissue (680-709)
<input type="checkbox"/> Diseases of the Musculoskeletal System and Connective Tissue (710-739)
<input type="checkbox"/> Congenital Anomalies (740-759)
<input type="checkbox"/> Certain Conditions Originating in Perinatal Period (760-779)
<input type="checkbox"/> Symptoms, Signs, and Ill-Defined Conditions (780-799)
<input type="checkbox"/> Injury and Poisoning (800-999) |
|--|---|

4. Axis IV. (Psychosocial or Environmental Stressors)

5. Axis V. (CGAS score) _____

**PART D: ANNUAL BEHAVIORAL HEALTH UPDATE AND
REVIEW SUMMARY: *BIRTH – 5***

III. RECOMMENDATIONS FOR CURRENT AND ONGOING SERVICE/TREATMENT

1. List prior goals that have not been achieved that still need to remain a focus of services/treatment:

2. List any new goals for the service plan:

3. List other ongoing needs or concerns that need to be addressed, including coordination of care with PCP:

4. Identify any areas in the assessment that need to be reassessed due to significant changes, e.g., child's condition, living environment, support structure:

Clinical Liaison's Name (print) / Signature

Credentials/Position

Date

Behavioral Health Professional Reviewer Name (print) / Signature

Credentials/Position

Date

Agency

REMINDER: All demographic data reported to ADHS/DBHS must be reviewed during annual update. Based on this review:

- At a minimum the following demographic/clinical data fields must be reported to ADHS/DBHS regardless of whether they have changed since the last data submittal: Axis I, II and V, behavioral health category, educational status, primary residence, since the last data update and primary and secondary substance use; and/or
- All other demographic information that has changed (e.g., other agency involvement, income for non-Title XIX/XXI eligibles).