Initial Behavioral Health Assessment

Provider Information	**Member Information**
TIN #: _____	**First Name:** _____
NPI ID: _____ **or Medicaid Provider ID:** _____	**Last Name:** _____
Name: _____	**DFPS ID:** _____ **or Medicaid ID:** _____
Phone: _____	**DOB:** _____
Fax: _____	
Service Date: _____	

Name of Placement and/or Residential Facility: _____

Placement Date: _____

I. DIAGNOSIS

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: Current GAF: _____ Highest in past year: _____

II. CURRENT PSYCHOTROPIC MEDICATIONS (If Known)

Medication	Dosage and Frequency	Physician	Start Date

	By History	Recent		By History	Recent
Suicide attempts	☐	☐	Fire setting	☐	☐
Suicide threats, ideation	☐	☐	Cruelty to animals	☐	☐
Physical aggression	☐	☐	Gang involvement	☐	☐
Self-injurious behavior	☐	☐	Use of emer. pers. restraint	☐	☐
Inappropriate sexual behavior	☐	☐	Use of emer. medications	☐	☐
Sexual perpetration	☐	☐	Failed placements	☐	☐
Substance abuse	☐	☐	Education deficits	☐	☐
Property destruction	☐	☐	Other_____	☐	☐
Runaway, threats, ideation	☐	☐			

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III. IQ TEST (If Applicable)

Test Given: _____

Administered By: _____

Date Given: _____

Results:

Verbal Score: _____

Performance Score: _____

Full Scale: _____

IV. OTHER TESTS ADMINISTERED (If Applicable)

Test Given: _____

Administered By: _____

Date Given: _____

Results: _____

Test Given: _____

Administered By: _____

Date Given: _____

Results: _____

Test Given: _____

Administered By: _____

Date Given: _____

Results: _____

V. BACKGROUND INFORMATION (include a description of the circumstances that led to the child's referral for substitute care including any history of physical, sexual, or emotional abuse or neglect and information regarding the child's family, social, and educational history.)

_____

_____

_____

_____

_____

_____

VI. PERMANENCY

- ☐ Reunification
- ☐ Adoption by relatives
- ☐ Adoption by others
- ☐ Permanent Managing Conservatorship by relative
- ☐ Permanent Managing Conservatorship by others
- ☐ Emancipation

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VII. BEHAVIORAL HEALTH STATUS (Include status of mental health. To meet DFPS Child Care Licensing* requirements for admission assessments and initial service plans, include substance abuse status, if applicable, and available results of any psychological or psychiatric examinations.)

_____
_____
_____
_____
_____
_____

VIII. STRENGTHS (Including physical, psychological, behavioral, social, and educational. To meet DFPS Child Care Licensing requirements for admission assessments, include any of the child's specific skills or special interests.)

_____
_____
_____
_____
_____
_____

IX. PRESENTING PROBLEMS (To meet DFPS Child Care Licensing requirements for admission assessments, include a description of the child's behavior, including appropriate and maladaptive behavior, and any high-risk behavior posing a risk to self or others.)

_____
_____
_____
_____
_____
_____

X. TREATMENT PLAN/GOALS

- the immediate and long-range goals for the treatment,
- the immediate and long-range goals related to permanency
- any directions or instructions to caregivers related to discipline, supervision, therapeutic strategies to address behaviors such as aggression or self harm, etc.

To meet Licensing requirements for admission assessments and initial service plans, include:

- the immediate and long-range goals for the placement,
- the child's therapeutic needs, including plans for therapy, psychological/psychiatric testing and follow-up treatment and use of psychotropic medication.
    - For children receiving treatment services as defined by Licensing: this should include a list of emotional, physical, and social needs that require specific professional expertise, and plans to obtain the appropriate professional consultation and treatment for those needs).

_____
_____
_____
_____
_____

* DFPS Child Care Licensing does not require that behavior health care providers document this information in the Health Passport. In fact, most of this information can be documented by various individuals and in any format designed by the residential child care provider. These are merely tips for those providers who wish for this documentation to meet the requirements of certain documentation required by DFPS Child Care Licensing.

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XI. TREATMENT MODALITY (Indicate Type and Frequency)

- ☐ Individual Therapy _____
- ☐ Family Therapy _____
- ☐ Group Therapy _____
- ☐ Rehabilitation Therapy _____
- ☐ Medication Management _____
- ☐ Other _____

XII. REFERRALS GIVEN (Include referral reason, date referred and to whom you are referring.)

_____
_____
_____
_____
_____
_____