MENTAL HEALTH SERVICES

2012

COMBINED UNIFORM CLINICAL RECORDS MANUAL

OCTOBER 2012

Revised January 2013

CLIENT DATA

NOTE: The most up to date Client Face Sheet and Discharge Summary is present in the Electronic Health Record. This section should contain any past paper Face Sheets and Discharge Summaries for the current program.

San Diego County Mental Health Services
Discharge Summary
Instructions

Client Name: This is a Required Field. Enter the client's name in this space provided.

Case #: This is a Required Field. Enter the case number in the space provided.

Program Name: This is a Required Field. Enter your unit name and number in the space provided.

Date of admission: This is a Required Field. Enter the information in the space provided.

Date of discharge: This is a Required Field. Enter the information in the space provided.

REASON FOR ADMISSION: This is a Required Field. Describe events in sequence leading to admission to your program. Describe primary complaint upon admission.

COURSE OF TREATMENT: Answer question regarding client plan goals by selecting the appropriate check boxes.

For significant diagnostic changes select "No" or "Yes" text box is provided for further information. Summary of services text box is provided to record response to treatment/progress and reason for discharge.

Aftercare Plan: Text box is provided for information provided to client/family at discharge and recommendation.

Housing/Living Arrangements at discharge: Entering the appropriate response in the space provided from choices listed in the Table below:

Living Arrangement		
A-House or Apartment	G-Substance Abuse Residential Rehab Ctr	O-Other
B-House or Apt with Support	H-Homeless/In Shelter	R-Foster Home-Child
C-House or Apt with Daily Supervision Independent Living Facility	I-MH Rehab Ctr (Adult Locked)	S-Group Home-Child (Level 1-12)
D-Other Supported Housing Program	J-SNF/ICF/IMD	T-Residential Tx Ctr-Child (Level 13-14)
E-Board & Care – Adult	K-Inpatient Psych Hospital	U-Unknown
F-Residential Tx/Crisis Ctr – Adult	L-State Hospital	V-Comm Tx Facility (Child Locked)
	M-Correctional Facility	W- Children's Shelter

Substance use treatment recommendations: Check boxes "Not Applicable" or "Yes" text box is provided for further information.

MEDICAL HISTORY

Medications at Discharge: List all medications dispensed or ordered at discharge.

Medication Adherence: Check the appropriate box, and explain in Comments text box as necessary client's compliance with medications.

Allergies and adverse medication reactions: Check "No", "Unknown/Nor Reported" or "Yes". If Yes, specify in comments box.

Other prescription medications: Check "None" or "Yes". If yes, specify in comments box.

Herbal/Dietary Supplements/over the counter medications: Check "None" or "Yes". If Yes, specify in comments box.

Healing and Health: Document in text box any healing and/or health practices made by client.

HISTORY OF VIOLENCE:

History of domestic violence: Check boxes “None Reported” or “Yes” text box is provided for further information.

History of significant property destruction: Check boxes “None Reported” or “Yes” text box is provided for further information.

History of Violence: Check boxes “None Reported” or “Yes” in text box specify intensity past or current.

History of Abuse: Check boxes “None Reported” or “Yes” in text box specify intensity past or current.

Abuse Reported: Check boxes “N/A”, “No” or “Yes”, if yes enter information in text box.

Experience of traumatic event(s): Check boxes “No” “Yes” “Unknown/Not Reported” if yes, describe traumatic experience and summarize impact in text box.

REFERRAL(S): This is a Required Field. Include culturally specific referral(s), referred to a higher level of care, referred to a lower level of care, referred to primary care physician for psychotropic medication, or reason why no referrals were provided, etc.

In the text boxes enter where client was referred, and the appointment date and time. Check the box if client or caregiver declined referral(s).

SIGNATURES: Enter the name, credential, date and Anasazi ID number for the clinician requiring a co-signature (if applicable); and/or the clinician completing/accepting the evaluation.

DIAGNOSIS
If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Discharge Summary.

DISCHARGE SUMMARY - EHR

2012

WHEN: When a client is seen five or more times, a discharge summary must be completed. When seen four or less times, a discharge progress note may be completed. The discharge summary must be completed in the EHR within 7 calendar days of the closing of the assignment. The clinician will only have access to the clinical forms for up to 7 days after the assignment is closed.

ON WHOM: Clients discharged from treatment at your Unit/SubUnit, or clients not seen for three months, unless the clinician has documented the reason for absence and it is reasonably expected that the client will receive services within six months.

COMPLETED BY: Staff delivering services within scope of practice. Must be signed by:

Physician,
Licensed/Waivered Psychologist,
Licensed/Registered/Waivered Social Worker,
Licensed/Registered/Waivered Marriage Family Therapist, or
Registered Nurse or Nurse Practitioner.

Co-signatures must be completed for the Discharge Summary to be final approved.

NOTE: The Children's System of Care does not allow the Discharge Summary to be completed by a MHRS staff.

REQUIRED ELEMENTS: All clinically appropriate elements should be completed.

NOTE: Every assessment within the EHR must be completed and final approved in a timely manner. When it is not completed and final approved (red locked), the system will prevent other servers from launching any assessments that contain shared fields. An assessment that is not final approved (status is "open green locked") is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Assessments are not viewed as complete and active until the assessment is final approved (red locked).

CLIENT FACE SHEET - EHR

2012

WHEN: Data is entered into the EHR when a client assignment is opened and when changes to any of the required elements occur. The Face Sheet is populated by information from the Demographic and Diagnosis Forms as well as from assignment/s entered into the Electronic Health Record (EHR). Since the Face Sheet lives in the EHR, and information on the client is updated in real time as data is entered into the EHR, a paper copy of the Face Sheet is not required to be placed in the paper/hybrid chart. The Face Sheet should be reviewed in the EHR on a quarterly basis at a minimum to assure all information is accurate and up to date.

ON WHOM: All clients with an open assignment.

COMPLETED BY: The EHR generates this printout based on information entered by each program that has an open assignment of the client. Traditionally this is entered by program's data entry/clerical staff.

MODE OF COMPLETION: For clients who are not previously opened in the system the following three forms are to be completed and entered into the EHR:

1. Demographic Form
2. Assignment Form
3. Diagnosis Form

For clients who are currently or previously opened in the EHR the following form is to be completed and entered:

1. Assignment Form.

Additionally, changes in the client status shall be entered into the EHR as they occur.

Upon closing of an assignment the following form is to be completed and entered:

1. Assignment Form.

REQUIRED ELEMENTS: The Demographic, Assignment and Diagnosis Forms must all be completed and entered into the EHR prior to printing the Face Sheet. If any information is not available at intake, it shall be obtained and entered into the EHR as soon as possible.

NOTE: This form is not a standard medical record form, therefore program discretion shall be exercised in determining whether to print out and maintain previous face sheets in the paper/hybrid record.

San Diego County Mental Health Services
DISCHARGE SUMMARY

***Client Name:** _____ ***Case #:** _____

***Discharge Date:** _____ ***Program Name:** _____

*Date of admission: _____

***REASON FOR ADMISSION** *Describe events in sequence leading to admission to your program. Describe primary complaint upon admission.*

_____
_____
_____
_____
_____

COURSE OF TREATMENT

Client Plan goal(s) were met?

☐ No ☐ Yes ☐ Partially ☐ Client did not return

Significant diagnostic changes during treatment: ☐ No ☐ Yes

_____
_____

Summary of Services: *Response to treatment/progress, and reason for discharge.*

_____
_____
_____
_____

Aftercare Plan: *Information provided to client/family at discharge and recommendations.*

_____
_____
_____

Housing/Living arrangements at discharge: *(Select from Living Arrangement table listed in the instruction sheet).*

_____

Substance use treatment recommendations: ☐ Not Applicable ☐ Yes

_____

MEDICAL HISTORY

Medications at Discharge:

_____
_____

Client Name: **Case #:**

Discharge Date: **Program Name:**

_____

Medication Adherence: ☐ Always ☐ Sometimes ☐ Rarely ☐Never ☐ Unknown
Comments: _____
Allergies and adverse medication reactions: ☐ No ☐ Unknown/Not Reported ☐ Yes
If Yes, Specify:_____
Other prescription medications: ☐ None ☐ Yes
If Yes,Specify:_____
Herbal/Dietary Supplements/over the counter medications: ☐ None ☐ Yes
If Yes,Specify:_____
Healing and Health:
_____

HISTORY OF VIOLENCE:

History of domestic violence: ☐ None reported ☐ Yes
-
_____
_____

History of significant property destruction: ☐ None reported ☐ Yes
_____
_____

History of violence: ☐ None reported ☐ Yes
Specify type, intensity, and if past or current.
_____
_____

History of abuse: ☐ None reported ☐ Yes
Specify type, intensity, and if past or current.
_____
_____

Abuse reported: ☐ N/A ☐ No ☐ Yes

If Yes, specify:
_____
_____

Experience of traumatic event(s):
☐ No ☐ Yes ☐ Unknown/not reported

If Yes: *Describe traumatic experience and summarize impact.*
_____
_____

***REFERRAL(S)**: *Include culturally specific referral(s), referred to a higher level of care, referred to a lower level of care, referred to primary care physician for psychotropic medication, or reason why no referrals were provided, etc.*

Client Name: **Case #:**

Discharge Date: **Program Name:**

_____
_____
_____
_____
_____

Referred to: _____

Appointment Date: _____ Time: _____

☐ Client or caregiver declined referral(s)

Signature of Clinician Requiring Co-signature:

_____ Date: _____
Signature

Printed Name: _____ Anasazi ID number: _____

Signature of Clinician Completing/Accepting the Assessment:

_____ Date: _____
Signature

Printed Name: _____ Anasazi ID number: _____

Signature of Staff Entering Information (if different from above):

_____ Date:
Signature

Printed Name: Anasazi ID number:

DIAGNOSIS

If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Discharge Summary

ASSESSMENTS

NOTE: The most up to date Assessments are present in the Electronic Health Record. This section should contain any paper past assessments for the current program.

INITIAL SCREENING - EHR

2012

WHEN: Initial client contact when services are requested (phone or walk-in contact).

NOTE: Initial Screening ESU is only to be used by the Emergency Screening Unit (ESU). All other programs are to use the Initial Screening form.

ON WHOM: Should be completed on all un-"opened" clients screened for services: when there is a significant issue, when the client is not likely to be opened to the program, or when the client is referred to another agency.
Not required if Behavioral Health Assessment is started/completed on first contact.

COMPLETED BY: Clinical staff participating in the client contact. May not be completed by clerical staff.

MODE OF COMPLETION: Data must be entered into the Electronic Health Record.

REQUIRED ELEMENTS: All clinically appropriate elements should be completed.

NOTE: Every assessment within the EHR must be completed and final approved in a timely manner. When it is not completed and final approved (red locked), the system will prevent other servers from launching any assessments that contain shared fields. An assessment that is not final approved (status is "open green locked") is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Assessments are not viewed as complete and active until the assessment is final approved (red locked).

San Diego County Mental Health Services
INITIAL SCREENING
Instructions

***Anasazi Tab 1*:**

TYPE OF CONTACT: This is a required field. Check box: "Telephone" "Face-to-Face".

PROGRAM: Enter your full program name in the space provided.

INFORMANT NAME: Enter the name of the person providing the information for the assessment.

RELATION TO CLIENT: Using the table below, enter the information on the form in the space provided.

ID	DESCRIPTION	ID	DESCRIPTION	ID	DESCRIPTION
Aunt Bio	Aunt – Biological	**Fath InLaw**	Father – In-Law	**Niece NBio**	Niece – Non-biological
Aunt NoBio	Aunt – Non-biological	**Gdaug Bio**	Granddaughter – Biological	**Other**	Other
Bro Adop	Brother – Adopted	**GDaug Nbio**	Granddaughter – Non-biological	**Signif Oth**	Significant Other
Bro Bio	Brother – Biological	**GrFa Bio**	Grandfather – Biological	**Sig Supp**	Significant Support Person
Bro Foster	Brother – Foster	**GrFa NBio**	Grandfather – Non-biological	**Sis Adopt**	Sister – Adopted
Bro InLaw	Brother – In-Law	**GrMo Bio**	Grandmother – Biological	**Sis Bio**	Sister – Biological
Bro Step	Brother – Step	**GrMo Nbio**	Grandmother – Non-biological	**Sis Foster**	Sister – Foster
Cous Bio	Cousin – Biological	**GrSon Bio**	Grandson – Biological	**Sis In Law**	Sister – In-Law
Cous Nbio	Cousin – Non-biological	**GrSon Nbio**	Grandson – Non-biological	**Sis Step**	Sister – Step
Daug Adopt	Daughter – Adopted	**Husband**	Husband	**Son Adopt**	Son – Adopted
Daug Bio	Daughter – Biological	**Mother Ado**	Mother – Adopted	**Son Bio**	Son – Biological
Daug Foster	Daughter – Foster	**Mother Bio**	Mother – Biological	**Son Foster**	Son – Foster
Daug InLaw	Daughter – In-Law	**Mother Fos**	Mother – Foster	**Son In Law**	Son – In-Law
Daug Step	Daughter – Step	**Mo In Law**	Mother – In-Law	**Son Step**	Son – Step
Dom Partner	Domestic Partner	**Mo Step**	Mother – Step	**Uncle Bio**	Uncle - Biological
Fath Adop	Father – Adopted	**Neph Bio**	Nephew – Biological	**Uncl NBio**	Uncle – Non-biological
Fath Bio	Father – Biological	**Neph NBio**	Nephew – Non-biological	**Wife**	Wife
Fath Fost	Father – Foster	**Niece Bio**	Niece – Biological		

IS CLIENT UNDER 18? This field is required. Check box "Yes" or "No".

PARENTAL INFORMATION: Enter parent name, relationship (select from relationship table above) address, home phone, employment phone, and any other information that might be helpful.

LEGAL INFORMATION:

Legal Consent: Select from the LEGAL STATUS table located in the Anasazi user manual. If status is different from the table, explain.

Responsible Person: Enter the name of the responsible person.

Relationship to the client: Enter the relationship to the client (select from relationship table located in the Anasazi user manual).

Enter address, home phone, employment phone and any other information that might be helpful.

CLIENT INFORMATION: Enter client's physical address, home phone and work phone.

WHOM CAN WE CALL BACK?: Enter the appropriate information in space provided.

PRESENTING PROBLEM: Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and history of present illness. Summary of client's request for services including client's most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behavior, including experiences of stigma and prejudice, if any.

URGENCY LEVEL: This is a required field. Indicate the appropriate urgency level by selecting the appropriate check box: "Routine" "Emergency" "Urgent" "Unspecified/Unknown".

INITIATE SECOND EFFORT: Check if second effort is initiated. Document assigned staff.

DATE SECOND EFFORT WAS INITIATED: Document any comments of second effort in space provided.

CLIENT REQUESTS/NEEDS: Check all that apply.

Description	**ID**
Psychiatric Assessment	P
Psychotherapy	T
Mental Health Assessment	M
Other	O

CURRENT MEDICATIONS: Indicate if client is currently taking medications by selecting the appropriate check-boxes "Yes" or "No". If client is taking psychotropic medications enter in medication table provided in the form.

HISTORY OF TREATMENT: Check box: "Outpatient" "Inpatient" or "Psychiatric Medications" by selecting the appropriate check-boxes. Provide a narrative description in the space provided.

Anasazi Tab 2

POTENTIAL FOR HARM/RISK:

Current suicidal ideation: Mark the appropriate check box "No" "Yes" "Unknown/Refused". Use the text box to specify plan "Vague" "Passive" "Imminent".

Access to Means: Mark the appropriate check box "No" "Yes" "Unknown/Refused". Use the text box to describe any information necessary.

Previous Attempts: Mark the appropriate check box "No" "Yes" "Unknown/Refused". Use the text box to describe any information necessary.

Does client agree not to hurt self or to seek help prior to acting on suicidal impulse: Mark the appropriate check box “No” “Yes” “Unknown/Refused”. Use the text box to explain any information necessary.

Current homicidal ideation: Mark the appropriate check box “No” “Yes” “Unknown/Refused”. Use the text box to specify plan “Vague” “Intent” “With/without means”.

Identified Victim: Check box “No” or “Yes”. If yes, answer “Tarasoff Warning Indicated” check box “No” or “Yes”. Answer reported to in text box and date.

Victim(s) name and contact information (Tarasoff Warning Details): Enter in text box.

Acts of property damage: Check box “No” or “Yes” If yes, enter most recent date. Use the text box to explain any information necessary.

Gravely Disabled: Check box “No” or “Yes”. Use the text box to explain any information necessary.

Current Domestic Violence: Check box “No” or “Yes”. Use the text box to describe situation.

SUBSTANCE USE: Check box: “No” “Yes” “Client Declined to Report”. Enter substances used in table provided.

Child/Adult Protective Services Notification Indicated: Check box “No” or “Yes”.

Use text box to indicate “reported to” and “date”.

Specify Domestic Violence Plan: (include Child/Adult Protective Services information) Enter information in text box.

Urine Drug Screen: Check box “Positive” “Negative” “Pending” “Refused” “N/A” use text boxes to enter any information necessary.

Breathalyzer: Check box “Positive” “Negative” “Pending” “Refused” “N/A” use text boxes to enter any information necessary.

Comments Regarding Factors Increasing Risk: Text box is provided to enter any information necessary.

Justice System Involvement: Check box “Yes” “No” or “Unknown” If yes, describe recent arrests, probation, sex offender information, et cetera in text box provided.

Anasazi Tab 3

INSURANCE: Check box: “No” or “Yes” If yes, select “Medical” Medicare” or “Other Insurance” and provide policy information.

OUTCOME/DISPOSITION: List the referrals made and document the outcome (including plan) in the spaces provided.

Referred to: Check all boxes that apply: “ADS” “Hospital/ER” “No Referral” “Other Community Services” “Specialty Mental Health Services”.

Referrals: Name of referral is a required field. List address, phone number, person to contact, directions and other instructions.

Describe Outcome, Including Plan: Describe the outcome including plan in space provided.

SIGNATURE OF STAFF COMPLETING SCREENING: Enter the name, credential, date and Anasazi ID number for the Staff completing the screening.

County of San Diego Mental Health Services
INITIAL SCREENING

***Client Name:** ***Case #:**

***Initial Screening Date:** ***Program Name:**

*Type of Contact: ☐ Telephone ☐ Face-to-Face

Informant Name: _____
Relation to Client *(Select from Relationship Table located in the Instruction Sheet)*: _____

*Is the client under 18? ☐ Yes ☐ No

PARENTAL INFORMATION:

Parent Name: _____
Relationship *(Select from Relationship Table located in the Instruction Sheet)*: _____
Address:_____ Phone: _____
City/State/Zip: _____
Employment Phone _____
Other Information: *For additional responsible parent/guardian(s), enter "See Contacts Field Below". Enter any other information that might be helpful in this field.*
_____
_____

LEGAL INFORMATION

Legal Consent: *(Select from Legal Status Table located in the Anasazi User Manual)* _____
If other: _____
Responsible Person: _____
Relationship *(Select from Relationship Table located in the Anasazi User Manual)* _____
Address _____ Phone: _____
City/State/Zip: _____
Employment Phone: _____
Other Information *Enter other information as needed. For AB2726 clients, enter the party who has educational signing rights. For example: "John Smith has Educational Rights".*
_____
_____

CLIENT INFORMATION:

Client's Physical Address: _____
City/State/Zip: _____
Home Phone: _____ Work Phone: _____
Whom can we call back? _____

***PRESENTING PROBLEM:** *Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and history of present illness. Summary of client's request for*

Client Name: **Case #:**

Initial Screening Date: **Program Name:**

services including client's most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behavior, including experiences of stigma and prejudice, if any.

_____
_____
_____
_____
_____
_____
_____
_____

*Urgency Level: ☐ Routine ☐ Emergency ☐ Urgent ☐ Unspecified/Unknown

☐ Initiate Second Effort Assigned Staff: _____

Date Second Effort Initiated: _____
Comments for Second Effort: _____

* Client Requests/Needs: *Check all that apply:*

☐ Psychiatric Assessment ☐ Psychotherapy ☐ Mental Health Assessment ☐ Other

Is client currently taking medications: ☐Yes ☐ No

Med	Start Date	Is Date Estima-ted Y or N	Dosage/ Frequency	Amt. Prescribed	Target Sxs	Taken as Pre-scribed? Y, N or Unk	Prescribing Physician Name	**	Refills	Stop Date	Reason for Stopping

***Physician Type**: 1. current psychiatrist (out of network) 2. current PCP 3. previous psychiatrist (out of network) 4. previous PCP*

History of Treatment: ☐ Outpatient ☐ Inpatient ☐ Psychiatric Medications

_____
_____
_____
_____

POTENTIAL FOR HARM/RISK ASSESSMENT

*Current Suicidal Ideation? ☐ No ☐Yes ☐Unknown/Refused

Specify plan (vague, passive, imminent):

_____
_____

Client Name: **Case #:**

Initial Screening Date: **Program Name:**

Access to Means? ☐ No ☐Yes ☐Unknown/Refused

Describe: _____

Previous Attempts? ☐ No ☐Yes ☐Unknown/Refused
Describe: _____

Does the client agree not to hurt self or to seek help prior to acting on suicidal impulse?
☐ No ☐Yes ☐Unknown/Refused
Explain: _____

*Current Homicidal Ideation? ☐ No ☐Yes ☐Unknown/Refused
Specify plan (vague, intent, with/without means):
_____
_____

Identified Victim(s)? ☐ No ☐Yes Tarasoff Warning Indicated? ☐ No ☐Yes

Reported To: _____Date: _____

Victim(s) name and contact information {Tarasoff Warning Details):
_____
_____

Acts of Property Damage? ☐ Yes ☐ No Most Recent Date: _____
_____
_____

Gravely Disabled? ☐ Yes ☐ No
_____

*Current Domestic Violence: ☐ No ☐Yes
Describe situation:
_____
_____

Child/Adult Protective Services Notification Indicated? ☐ No ☐Yes
Reported to: _____Date: _____

Specify Domestic Violence Plan (include Child/Adult Protective Services information):
_____
_____
_____

***Substance Use?** ☐ **No** ☐ **Yes** ☐ **Client declined to report**

Client Name: **Case #:**

Initial Screening Date: **Program Name:**

If Yes, specify substances used:

Name of Drug	Priority	Method of Admin-istration	Age 1st used	Freq-uency of Use	Days of use in last 30 days	Date of last use	Amount of last use	Amount used on a typical Day	Largest Amount Used in One Day

Urine Drug Screen: ☐ Positive ☐ Negative ☐ Pending ☐ Refused ☐ N/A

_____

Breathalyzer: ☐ Positive ☐ Negative ☐ Pending ☐ Refused ☐ N/A

_____

Comments Regarding Factors Increasing Risk:

_____

_____

Justice System Involvement? ☐ Yes ☐ No ☐Unknown

If yes, describe recent arrests, probation, sex offender information, et cetera:

_____

_____

_____

Insurance:

☐ No ☐ Yes ☐ MediCal _____ ☐ Medicare _____

☐ Other Insurance: _____

<u>OUTCOME/DISPOSITION</u>

Referred to: *Check all that apply*

☐ ADS ☐ Hospital/ER ☐ No Referral ☐ Other Community Services
☐ Specialty Mental Health Services

Referrals

*Name _____
Address _____
City/State/ZIP _____
Phone _____
Person to Contact _____

Client Name: **Case #:**

Initial Screening Date: **Program Name:**

Directions or Other Instructions _____

Describe Outcome, Including Plan:

_____

_____

_____

Signature of Staff Completing Screening:

_____ **Date** _____ **Time** _____

Signature

Printed Name _____ **Anasazi ID number** _____

San Diego County Mental Health Services
INITIAL SCREENING -- ESU
Instructions

***Anasazi Tab 1*:**

TYPE OF CONTACT: This is a required field. Check box: "Telephone" "Face-to-Face".

PROGRAM: Enter your full program name in the space provided.

INFORMANT NAME: Enter the name of the person providing the information for the assessment.

RELATION TO CLIENT: Using the table below, enter the information on the form in the space provided.

ID	DESCRIPTION	ID	DESCRIPTION	ID	DESCRIPTION
Aunt Bio	Aunt – Biological	**Fath InLaw**	Father – In-Law	**Niece NBio**	Niece – Non-biological
Aunt NoBio	Aunt – Non-biological	**Gdaug Bio**	Granddaughter – Biological	**Other**	Other
Bro Adop	Brother – Adopted	**GDaug Nbio**	Granddaughter – Non-biological	**Signif Oth**	Significant Other
Bro Bio	Brother – Biological	**GrFa Bio**	Grandfather – Biological	**Sig Supp**	Significant Support Person
Bro Foster	Brother – Foster	**GrFa NBio**	Grandfather – Non-biological	**Sis Adopt**	Sister – Adopted
Bro InLaw	Brother – In-Law	**GrMo Bio**	Grandmother – Biological	**Sis Bio**	Sister – Biological
Bro Step	Brother – Step	**GrMo Nbio**	Grandmother – Non-biological	**Sis Foster**	Sister – Foster
Cous Bio	Cousin – Biological	**GrSon Bio**	Grandson – Biological	**Sis In Law**	Sister – In-Law
Cous Nbio	Cousin – Non-biological	**GrSon Nbio**	Grandson – Non-biological	**Sis Step**	Sister – Step
Daug Adopt	Daughter – Adopted	**Husband**	Husband	**Son Adopt**	Son – Adopted
Daug Bio	Daughter – Biological	**Mother Ado**	Mother – Adopted	**Son Bio**	Son – Biological
Daug Foster	Daughter – Foster	**Mother Bio**	Mother – Biological	**Son Foster**	Son – Foster
Daug InLaw	Daughter – In-Law	**Mother Fos**	Mother – Foster	**Son In Law**	Son – In-Law
Daug Step	Daughter – Step	**Mo In Law**	Mother – In-Law	**Son Step**	Son – Step
Dom Partner	Domestic Partner	**Mo Step**	Mother – Step	**Uncle Bio**	Uncle – Biological
Fath Adop	Father – Adopted	**Neph Bio**	Nephew – Biological	**Uncl NBio**	Uncle – Non-biological
Fath Bio	Father – Biological	**Neph NBio**	Nephew – Non-biological	**Wife**	Wife
Fath Fost	Father – Foster	**Niece Bio**	Niece – Biological		

IS CLIENT UNDER 18? This field is required. Check box "Yes" or "No".

PARENTAL INFORMATION: Enter parent name, relationship (select from relationship table above) address, home phone, employment phone, and any other information that might be helpful.

SIGNIFICANT SUPPORT PERSONS: Include name, relationship and phone in space provided.

LEGAL INFORMATION:

Legal Consent: Select from the LEGAL STATUS table located in the Anasazi user manual. If status is different from the table, explain.

Responsible Person: Enter the name of the responsible person.

Relationship to the client: Enter the relationship to the client (select from relationship table located in the Anasazi user manual).

Enter address, home phone, employment phone and any other information that might be helpful.

CLIENT INFORMATION: Enter client's physical address, home phone and work phone.

SCHOOL ATTENDING, CURRENT GRADE, WHOM CAN WE CALL BACK?: Enter the appropriate information in space provided.

PRESENTING PROBLEM: Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and summary of client's request for services including client's most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors. Include information on 5150 and Police transport.

URGENCY LEVEL: This is a required field. Indicate the appropriate urgency level by selecting the appropriate check box: "Routine" "Emergency" "Urgent" "Unspecified/Unknown".

CURRENTLY ON 5150: Check box: "No" "Yes". If Yes, specify: "Danger to Self" "Danger to Others" "Gravely Disabled"

CLIENT REQUESTS/NEEDS: Check all that apply.

Description	**ID**
Psychiatric Assessment	P
Psychotherapy	T
Mental Health Assessment	M
Other	O

CURRENT MEDICATIONS: Indicate if client is currently taking medications by selecting the appropriate check-boxes "Yes" or "No". If client is taking psychotropic medications enter in medication table provided in the form.

CURRENT THERAPIST/CLINICIAN: Enter current therapist or clinician in space provided.

HISTORY OF TREATMENT: Check box: "Outpatient" "Inpatient" or "Psychiatric Medications" by selecting the appropriate check-boxes. Provide a narrative description in the space provided.

Anasazi Tab 2

POTENTIAL FOR HARM/RISK:

Current suicidal ideation: Mark the appropriate check box “No” “Yes” “Unknown/Refused”. Use the text box to specify plan “Vague” “Passive” “Imminent”.

Access to Means: Mark the appropriate check box “No” “Yes” “Unknown/Refused”. Use the text box to describe any information necessary.

Previous Attempts: Mark the appropriate check box “No” “Yes” “Unknown/Refused”. Use the text box to describe any information necessary.

Does client agree not to hurt self or to seek help prior to acting on suicidal impulse: Mark the appropriate check box “No” “Yes” “Unknown/Refused”. Use the text box to explain any information necessary.

Current homicidal ideation: Mark the appropriate check box “No” “Yes” “Unknown/Refused”. Use the text box to specify plan “Vague” “Intent” “With/without means”.

Identified Victim: Check box “No” or “Yes”. If yes, answer “Tarasoff Warning Indicated” check box “No” or “Yes”. Answer reported to in text box and date.

Victim(s) name and contact information (Tarasoff Warning Details): Enter in text box.

Acts of property damage: Check box “No” or “Yes” If yes, enter most recent date. Use the text box to explain any information necessary.

Gravely Disabled: Check box “No” or “Yes”. Use the text box to explain any information necessary.

Current Domestic Violence: Check box “No” or “Yes”. Use the text box to describe situation.

SUBSTANCE USE: Check box: “No” “Yes” “Client Declined to Report”. Enter substances used in table provided.

Child/Adult Protective Services Notification Indicated: Check box “No” or “Yes”.

Use text box to indicate “reported to” and “date”.

Specify Domestic Violence Plan: (include Child/Adult Protective Services information) Enter information in text box.

Urine Drug Screen: Check box “Positive” “Negative” “Pending” “Refused” “N/A” use text boxes to enter any information necessary.

Breathalyzer: Check box “Positive” “Negative” “Pending” “Refused” “N/A” use text boxes to enter any information necessary.

Comments Regarding Factors Increasing Risk: Text box is provided to enter any information necessary.

Justice System Involvement: Check box “Yes” “No” or “Unknown” If yes, describe recent arrests, probation, sex offender information, et cetera in text box provided.

Anasazi Tab 3

SOCIAL SECURITY NUMBER: Enter client's social security number.

INSURANCE: Check box: "No" or "Yes" If yes, select "Medical" Medicare" or "Other Insurance" and provide policy information.

OUTCOME/DISPOSITION: List the referrals made and document the outcome (including plan) in the spaces provided.

Referred to: Check all boxes that apply: "ADS" "Hospital/ER" "No Referral" "Other Community Services" "Specialty Mental Health Services".

Referrals: Name of referral is a required field. List address, phone number, person to contact, directions and other instructions.

Describe Outcome, Including Plan: Describe the outcome including plan in space provided.

SIGNATURE OF STAFF COMPLETING SCREENING: Enter the name, credential, date and Anasazi ID number for the Staff completing the screening.

County of San Diego Mental Health Services
INITIAL SCREENING-ESU

*Client Name: _____ *Case Number: _____
*Assessment Date: _____ *Program Name: _____

*Type of Contact: ☐ Telephone ☐ Face-to-Face

Informant Name: _____
Relation to Client *(Select from Relationship Table located in the Instruction Sheet)*: _____

*Is the client under 18? ☐ Yes ☐ No

PARENTAL INFORMATION:

Parent Name: _____
Relationship *(Select from Relationship Table located in the Instruction Sheet)*: _____
Address:_____ Phone: _____
City/State/Zip: _____
Employment Phone _____
Other Information: *For additional responsible parent/guardian(s), enter "See Contacts Field Below". Enter any other information that might be helpful in this field.*
_____
_____

Significant Support Persons *Include Name, Relationship and Phone:*
_____

LEGAL INFORMATION

Legal Consent: *(Select from Legal Status Table located in the Anasazi User Manual)* _____
If other: _____
Responsible Person: _____
Relationship *(Select from Relationship Table located in the Anasazi User Manual)* _____
Address _____ Phone: _____
City/State/Zip: _____
Employment Phone: _____
Other Information *Enter other information as needed. For AB2726 clients, enter the party who has educational signing rights. For example: "John Smith has Educational Rights".*
_____
_____

CLIENT INFORMATION:

Client's Physical Address: _____
City/State/Zip: _____
Home Phone: _____ Work Phone: _____
School Attending: _____Current Grade: _____

Client Name: **Case #**

Date of Initial Screening: **Program Name:**
Whom can we call back? _____

<u>*PRESENTING PROBLEM:</u> Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and summary of client's request for services including client's most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors. Include information on 5150 and Police transport.

_____
_____
_____
_____
_____
_____
_____
_____

*Urgency Level: ☐ Routine ☐ Emergency ☐ Urgent ☐ Unspecified/Unknown

Currently on 5150? ☐ No ☐ Yes
☐ Danger to Self ☐ Danger to Others ☐ Gravely Disabled

Client Requests/Needs: *Check all that apply:*

☐ Psychiatric Assessment ☐ Psychotherapy ☐ Mental Health Assessment ☐ Other

Is client currently taking medications: ☐Yes ☐ No

Med	Start Date	Is Date Estima-ted Y or N	Dosage/ Frequency	Amt. Prescribed	Target Sxs	Taken as Pre-scribed? Y, N or Unk	Prescribing Physician Name	**	Refills	Stop Date	Reason for Stopping

***Physician Type**: 1. current psychiatrist (out of network) 2. current PCP 3. previous psychiatrist (out of network) 4. previous PCP*

Current Therapist/Clinician (Include Name and Phone Number):
_____

History of Treatment: ☐ Outpatient ☐ Inpatient ☐ Psychiatric Medications
_____
_____
_____
_____

Client Name: **Case #**

Date of Initial Screening: **Program Name:**

POTENTIAL FOR HARM/RISK ASSESSMENT

*Current Suicidal Ideation? ☐ No ☐Yes ☐Unknown/Refused

Specify plan (vague, passive, imminent):

_____

_____

Access to Means? ☐ No ☐Yes ☐Unknown/Refused

Describe: _____

Previous Attempts? ☐ No ☐Yes ☐Unknown/Refused

Describe: _____

Does the client agree not to hurt self or to seek help prior to acting on suicidal impulse?

☐ No ☐Yes ☐Unknown/Refused

Explain: _____

*Current Homicidal Ideation? ☐ No ☐Yes ☐Unknown/Refused

Specify plan (vague, intent, with/without means):

_____

_____

Identified Victim(s)? ☐ No ☐Yes Tarasoff Warning Indicated? ☐ No ☐Yes

Reported To: _____Date: _____

Victim(s) name and contact information {Tarasoff Warning Details):

_____

_____

Acts of Property Damage? ☐ Yes ☐ No Most Recent Date: _____

_____

_____

Gravely Disabled? ☐ Yes ☐ No

_____

*Current Domestic Violence: ☐ No ☐Yes

Describe situation:

_____

_____

Child/Adult Protective Services Notification Indicated? ☐ No ☐Yes

Reported to: _____Date: _____

Client Name: **Case #**

Date of Initial Screening: **Program Name:**

Specify Domestic Violence Plan (include Child/Adult Protective Services information):

_____

_____

_____

***Substance Use?** ☐ **No** ☐ **Yes** ☐ **Client declined to report**

If Yes, specify substances used:

Name of Drug	Priority	Method of Admin-istration	Age 1st used	Freq-uency of Use	Days of use in last 30 days	Date of last use	Amount of last use	Amount used on a typical Day	Largest Amount Used in One Day

Urine Drug Screen: ☐ Positive ☐ Negative ☐ Pending ☐ Refused ☐ N/A

_____

Breathalyzer: ☐ Positive ☐ Negative ☐ Pending ☐ Refused ☐ N/A

_____

Comments Regarding Factors Increasing Risk:

_____

_____

Justice System Involvement? ☐ Yes ☐ No ☐Unknown

If yes, describe recent arrests, probation, sex offender information, et cetera:

_____

_____

_____

Social Security #: _____

Insurance:

☐ No ☐ Yes ☐ MediCal _____ ☐ Medicare _____

☐ Other Insurance: _____

Client Name: **Case #**

Date of Initial Screening: **Program Name:**

OUTCOME/DISPOSITION

Referred to: *Check all that apply*

☐ ADS ☐ Hospital/ER ☐ No Referral ☐ Other Community Services
☐ Specialty Mental Health Services

Referrals
*Name _____
Address _____
City/State/ZIP _____
Phone _____
Person to Contact _____
Directions or Other Instructions _____

Describe Outcome, Including Plan:
_____
_____
_____

Signature of Staff Completing Screening:

_____ **Date** _____ **Time** _____
Signature

Printed Name _____ **Anasazi ID number** _____

BEHAVIORAL HEALTH ASSESSMENTS - EHR

2012

WHEN: Within 30 calendar days of opening the client's first consecutive open assignment (associated with a notification – follow the system notifications). When significant changes occur the assessment may be revised by opening a new assessment, adding the updated information, and final approving the assessment. BHA must be every 12 months at a minimum (based on the system notifications).

ON WHOM: All clients receiving mental health services.

COMPLETED BY: Staff delivering services within scope of practice. Must be signed by:

Physician,
Licensed/Waivered Psychologist,
Licensed/Registered/Waivered Social Worker,
Licensed/Registered/Waivered Marriage Family Therapist, or
Registered Nurse, Nurse Practitioner, or
Licensed Psychiatry Technician
Trainee can complete but must be co-signed by one of the above.

Co-signatures must be completed for the Behavioral Health Assessment to be final approved.

NOTE: The children system of care does not allow the BHA be completed by an MHRS staff.
The adult system of care does allow the BHA be completed by an MHRS staff with a co-signature.

MODE OF COMPLETION: Data must be entered into the Electronic Health Record.

REQUIRED ELEMENTS: All clinically appropriate elements should be completed.

NOTE: Every assessment within the EHR must be completed and final approved in a timely manner. When it is not completed and final approved (red locked), the system will prevent other servers from launching any assessments that contain shared fields. An assessment that is not final approved (status is "open green locked") is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Assessments are not viewed as complete and active until the assessment is final approved (red locked).

SAFETY ALERTS - EHR

2012

WHEN: Safety Alerts should be used by the clinician to alert other clinicians of a possible safety risk with the client. The clinician shall exercise caution in selecting from this list as it will be visible on the client Face Sheet. The Safety Alert shall be updated when the alert no longer pertains to the client.

ON WHOM: ONLY a client requiring a Safety Alert.

COMPLETED BY: Clinical staff that have completed a thorough evaluation of the safety risks. It is expected that clinical staff consult with supervisor and/or peers before determining a system-wide Safety Alert is warranted. Reminder: the Safety Alert will be viewed by all programs working with the client.

MODE OF COMPLETION: Data must be entered into the Electronic Health Record.

NOTE: **0-5 Kids, Children, ESU, and TBS:**
The children system of care does not allow the Safety Alert be completed by an MHRS staff.

REQUIRED ELEMENTS: All clinically appropriate elements should be completed.

NOTE: Every assessment within the EHR must be completed and final approved in a timely manner. When it is not completed and final approved (red locked), the system will prevent other servers from launching any assessments that contain shared fields. An assessment that is not final approved (status is “open green locked”) is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Assessments are not viewed as complete and active until the assessment is final approved (red locked).

San Diego County Mental Health Services
SAFETY ALERTS
Instructions

This Form, when completed in Anasazi, will auto-populate the top portion of the Face Sheet.

The Face Sheet in Anasazi is designed to pull information from other forms only and can not be changed or updated on its own. Therefore, any change or update that needs to be made to Safety Alert information will require a new Safety Alert form to be completed.

PROGRAM NAME: Enter your full program name in the space provided.

DATE COMPLETED: Enter the date the information

ALLERGIES AND ADVERS MEDICATION REACTIONS: Select the appropriate check-box from those provided. If "Yes," document details in the space provided.

SAFETY ALERTS: Using the table below, select the appropriate concern(s) and list on the form in the spaces provided. Provide narrative documentation in the space provided.

ID	Description
Tarasoff	Previous history of Tarasoff
Con substance	Hx of prog shop for control substances
Suicide	Hx of near lethal suicide attempts
Comnd Hal	Command Hallucinations
Violence	History of violence towards staff
Other	Other

SIGNATURE: Enter the name, credential, date and Anasazi ID number for the staff completing the screening.

Client Name:_____ **Case #:** _____
Date: _____ ***Program Name**: _____

San Diego County Mental Health Services
SAFETY ALERTS

*Program Name: _____

Date Completed: _____

*Allergies and Adverse Medication Reactions: ☐ No ☐ Unknown/Not Reported ☐Yes
If Yes, specify: _____
_____
_____

Safety Alerts (Select from Safety Alerts table listed in the Instructions Sheet):
_____
_____
_____
_____
_____
_____
_____

Signature of Staff Member Obtaining Information:

_____ _____ _____
Signature Date Time

_____ _____
Printed Name Anasazi ID number

Signature of Staff Entering Information (if different from above):

_____ _____ _____
Signature Date Time

_____ _____
Printed Name Anasazi ID number

BEHAVIORAL HEALTH ASSESSMENTS - EHR

2012

WHEN: Within 30 calendar days of opening the client's first consecutive open assignment (associated with a notification – follow the system notifications). When significant changes occur the assessment may be revised by opening a new assessment, adding the updated information, and final approving the assessment. BHA must be every 12 months at a minimum (based on the system notifications).

ON WHOM: All clients receiving mental health services.

COMPLETED BY: Staff delivering services within scope of practice. Must be signed by:

Physician,
Licensed/Waivered Psychologist,
Licensed/Registered/Waivered Social Worker,
Licensed/Registered/Waivered Marriage Family Therapist, or
Registered Nurse, Nurse Practitioner, or
Licensed Psychiatry Technician
Trainee can complete but must be co-signed by one of the above.

Co-signatures must be completed for the Behavioral Health Assessment to be final approved.

NOTE: The children system of care does not allow the BHA be completed by an MHRS staff.
The adult system of care does allow the BHA be completed by an MHRS staff with a co-signature.

MODE OF COMPLETION: Data must be entered into the Electronic Health Record.

REQUIRED ELEMENTS: All clinically appropriate elements should be completed.

NOTE: Every assessment within the EHR must be completed and final approved in a timely manner. When it is not completed and final approved (red locked), the system will prevent other servers from launching any assessments that contain shared fields. An assessment that is not final approved (status is "open green locked") is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Assessments are not viewed as complete and active until the assessment is final approved (red locked).

San Diego County Mental Health Services
BEHAVIORAL HEALTH ASSESSMENT - ADULT
Instructions

CLIENT NAME: Required Field

CASE #- Required Field.

ASSESSMENT DATE: Required Field

PROGRAM NAME- Required Field.

LEGAL STATUS/CASE MANAGER/PAYEE: Make the appropriate selections for type of conservatorship and case management by marking the corresponding check boxes for these items. Enter payee and probation officer information, if applicable, in the spaces provided.

SOURCE OF INFORMATION- Required Field. Select from the Source of information Table below. Include the ID and Description in your documentation. If "Other" is selected, please provide information.

ID	Description	ID	Description
AB2726 Asr	AB2726 Assessor	**Other**	Other
ADS Prov	ADS Recovery Provider	**Parent LG**	Parent/Legal Guardian
Client	Client	**Prev Asst**	Previous Assessment
Case Mnager	Case Manager	**Probation/Parole Officer**	Probation/Parole Officer
Conservatr	Conservator	**Soc Worker**	Social Worker
Family	Family	**Teacher**	Teacher/School
Fos Parent	Foster Parent	**Therapist**	Therapist
MD	MD		

REPORTS REVIEWED: Enter any reports used as part of the assessment.

REFERRAL SOURCE: Enter name of referral source here.

PRESENTING PROBLEMS/NEEDS: Required field. Write in the area provided, using the help text as a guide.

PAST PSYCHIATRIC HISTORY: **Required field.** Write in the area provided, using the help text as a guide.

MEDICAL HISTORY: The "Does client have a Primary Care Physician?" **is Required**. The "Physical Health Issues" prompt **is Required**. The "allergies and adverse medication reactions" prompt **is Required**.

For the rest of this section, enter the appropriate check marks and text as indicated.
For the "Healing and Health" section: Write in the area provided, using the help text as a guide.

FAMILY HISTORY:

LIVING ARRANGEMENT: **A Required Field**.

Select from the Living Arrangement Table below. Include the ID and Description in your documentation. If "Other" is selected, please provide information.

Living Arrangement		
A-House or Apartment B-House or Apt with Support C-House or Apt with Daily Supervision Independent Living Facility D-Other Supported Housing Program E-Board & Care – Adult F-Residential Tx/Crisis Ctr – Adult	G-Substance Abuse Residential Rehab Ctr H-Homeless/In Shelter I-MH Rehab Ctr (Adult Locked) J-SNF/ICF/IMD K-Inpatient Psych Hospital L-State Hospital M-Correctional Facility	O-Other R-Foster Home-Child S-Group Home-Child (Level 1-12) T-Residential Tx Ctr-Child (Level 13-14) U-Unknown V-Comm Tx Facility (Child Locked) W- Children's Shelter

THOSE LIVING IN THE HOME WITH THE CLIENT: List the names and relationship to client, and other pertinent information, in the space provided.

HAVE ANY RELATIVES EVER HAD ANY OF THE FOLLOWING CONDITIONS: For each listed condition, enter information from the family members table, if applicable, in the spaces provided. Leave blank if there are none:

ID	DESCRIPTION	ID	DESCRIPTION	ID	DESCRIPTION
Aunt Bio	Aunt – Biological	**Fath InLaw**	Father – In-Law	**Niece Bio**	Niece – Biological
Aunt NoBio	Aunt – Non-biological	**Fath Step**	Father-Step	**Niece NBio**	Niece – Non-biological
Bro Adop	Brother – Adopted	**Gdaug Bio**	Granddaughter – Biological	**Other**	Other
Bro Bio	Brother – Biological	**GDaug Nbio**	Granddaughter – Non-biological	**Sis Adop**	Sister-Adopted
Bro Foster	Brother – Foster	**GrFa Bio**	Grandfather – Biological	**Sis Bio**	Sister-Biological
Bro InLaw	Brother – In-Law	**GrFa NBio**	Grandfather – Non-biological	**Sis Foster**	Sister – Foster
Bro Step	Brother – Step	**GrMo Bio**	Grandmother – Biological	**Sis InLaw**	Sister – In-Law
Cous Bio	Cousin – Biological	**GrMo Nbio**	Grandmother – Non-biological	**Sis Step**	Sister – Step
Cous Nbio	Cousin – Non-biological	**GrSon Bio**	Grandson – Biological	**Son Adopt**	Son-Adopted
Daug Adopt	Daughter – Adopted	**GrSon Nbio**	Grandson – Non-biological	**Son Bio**	Son – Biological
Daug Bio	Daughter – Biological	**Husband**	Husband	**Son Foster**	Son – Foster
Daug Foster	Daughter – Foster	**Mother Ado**	Mother – Adopted	**Son in Law**	Son – In-Law
Daug InLaw	Daughter – In-Law	**Mother Bio**	Mother – Biological	**Son Step**	Son – Step
Daug Step	Daughter – Step	**Mother Fos**	Mother – Foster	**Signif Oth**	Significant Other
Dom Partner	Domestic Partner	**Mo In Law**	Mother – In-Law	**Sig Supp**	Significant Support Person
Fath Adop	Father – Adopted	**Mo Step**	Mother – Step	**Uncle Bio**	Uncle - Biological
Fath Bio	Father – Biological	**Neph Bio**	Nephew – Biological	**Uncl NBio**	Uncle – Non-biological
Fath Fost	Father – Foster	**Neph NBio**	Nephew – Non-biological	**Wife**	Wife

Include relevant family information impacting the client: (Further explain family member's involvement in substance use)

EDUCATIONAL/EMPLOYMENT HISTORY: Check all "Areas of Concen" boxes that apply. Complete the other prompts as applicable.

MILITARY HISTORY: Enter requested information in the spaces provided.

CULTURAL INFORMATION: Write in the area provided.

SEXUAL ORIENTATION/GENDER IDENTITY: Select from choices available.

SOCIAL HISTORY: Check all boxes as applicable. Give explanations for all "yes" answers. For Family/Community support system, include alternate relationship support, if any, for mental health and/or substance use such as supportive/community groups, AA/NA. For Religious/Spiritual issues, document if religion/spirituality is important in a client's life and/or a source of strength. Describe persons and practices, and how they are important. For Justice System Involvement, describe what system, extent, probation/parole, time served, etc.

HISTORY OF VIOLENCE: Check all boxes as applicable. Give explanations for all "yes" answers

SUBSTANCE USE INFORMATION: This is a Required Field. Check all boxes as applicable. Give explanations for all "yes" answers.

Educate the client regarding the effects of smoking by reading the following statement: "Smoking is a serious health risk that may lead to lung cancer, cardiovascular disease and the possibility of premature death." Indicate you have provided this advisement by selecting the "Yes" check box.

MMSE (Mini Mental Status Exam): Enter 2 digit code

FUNCTIONAL ASSESSMENT: Enter a narrative description for each item listed in the spaces provided. Check boxes are listed for Somatic Safety and Basic Self-Care.

Address if housing is at risk.

RECENT DEATHS, DEATH ANNIVERSAIRIES: List information in the spaces provided.

DECISION MAKER: Indicate the Name and Relationship in the spaces provided, if applicable.

FAMILY LEVEL OF INVOLVEMENT: Indicate by marking the appropriate check box.

PRIMARY CARE GIVER/ CAREGIVER RESOURCES KNOWN OF -- USED: Include relevant name(s) and other information in the space provided.

CAREGIVER BURDEN LEVEL: Indicate by marking the appropriate check boxes.

ILLNESS MANAGEMENT: Indicate answers by selecting the appropriate check boxes.

RECOMMENDATIONS: Check the appropriate boxes, as indicated.

MENTAL STATUS, CASE MANAGEMENT, POTENTIAL FOR HARM, STRENGTHS, AREAS OF NEED: Provide answers for items in these domains by selecting the appropriate check boxes or entering requested text in the spaces provided. Consult form Help Texts as available.

DIAGNOSIS
If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Behavioral Health Assessment.

Anasazi Tab 8: "BHA Signature Page"

CLINICAL CONCLUSION: Document justification and medical necessity in the space provided, using the form's Help Text as a guide.

RECOMMENDATIONS/MEDICAL NECESSITY MET: Check the appropriate boxes, as indicated.

CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE: Provide the dates and check each item as completed.

Signatures: The clinician completing the form will sign his/her name with credential on the signature line, and print their name on the second line. Date and Anasazi Staff ID number are documented at the appropriate prompts.

When a clinician needs a co-signature, a qualified clinician will sign, print name, date and enter Anasazi Staff ID as indicated. Refer to Scope of Practice to identify who needs a co-signature.

San Diego County Mental Health Services
BEHAVIORAL HEALTH ASSESSMENT – ADULT

***Client Name**: _____ ***Case #:** _____

***Assessment Date:** _____ * **Program Name**: _____

LEGAL STATUS/CASE MANAGER/PAYEE

Conservator: ☐LPS ☐Probate ☐Temporary ☐None
Case Manager: ☐Intensive ☐FSP ☐Institutional ☐SBCM
☐None: _____
Payee: _____

Probation Officer: _____

***SOURCE OF INFORMATION** *Select from Source of Information Table located in the Instructions sheet*

_____

If a source other than listed on the "Source of Information" Table, specify
_____

Reports Reviewed: _____
Referral Source: _____

***PRESENTING PROBLEMS/NEEDS** *Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and history of present illness. Summary of client's request for services including client's most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors; include experiences of stigma and prejudice, if any.*

_____
_____
_____
_____
_____
_____
_____
_____

***PAST PSYCHIATRIC HISTORY** *Previous history of symptoms and/or mental health treatment. Describe in chronological order - where, when, and length of time. Include dates and providers related to any prior psychiatric treatment, history, traumatic and/or significant events, and/or trauma related to treatment. Include the most recent periods of stability and the characteristics of those periods.*

_____
_____
_____
_____
_____
_____
_____

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

MEDICAL HISTORY:

*Does client have a Primary Care Physician? ☐No ☐Yes ☐ Unknown

If No, has client been advised to seek primary care? ☐No ☐Yes

Primary Care Physician: _____

Phone Number: _____

Seen within the last: ☐ 6 months ☐ 12 months ☐ Other: _____

Hospital of choice (physical health): _____

Been seen for the following (provide dates of last exam):

Dental exam: _____

Hearing exam: _____

Vision exam: _____

*Physical Health issues: ☐None at this time ☐Yes

If Yes, specify: _____

_____

_____

Is condition followed by Primary Care Physician? ☐No ☐Yes ☐N/A

Physical health problems affecting mental health functioning:

_____

_____

Head injuries: ☐No ☐Yes

If Yes, specify: _____

_____

_____

Medical and/or adaptive devices: _____

Significant Developmental Information (when applicable): _____

_____

*Allergies and adverse medication reactions: ☐No ☐Unknown/Not Reported ☐ Yes

If Yes, specify: _____

_____

_____

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

Medications (Active and Current Inactivations):

Med	Start Date	Is Date Estimated Y or N	Dosage/ Frequency	Amt. Prescribed	Target Sxs	Taken as Pre-scribed? Y, N or Unk	Prescribing Physician Name	**	Refills	Stop Date	Reason for Stopping

*****Physician Type**: 1. current psychiatrist (out of network) 2. current PCP 3. previous psychiatrist (out of network) 4. previous PCP*

Other prescription medications: ☐None ☐Yes: _____

Herbals/Dietary Supplements/Over the counter medications: ☐None ☐Yes:

_____

_____

Healing and Health: *Alternative healing practices and beliefs. Apart from mental health professionals, who or what helps client deal with disability/illness and/or to address substance use issues? Describe.*

_____

_____

_____

FAMILY HISTORY:

*Living Arrangement: *Select from Living Arrangement table listed in the Instructions Sheet*

_____

Those living in the home with client: _____

_____

Have any relatives ever had any of the following conditions
Select from Relatives table listed in the Instructions Sheet
.

Substance abuse or addiction: _____
Other addictions: _____
Suicidal thoughts, attempts: _____
Emotional/mental health issues: _____
Mental retardation: _____
Developmental delays: _____
Arrests: _____

Include relevant family information impacting the client: _____

_____

_____

_____

_____

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

EDUCATIONAL/EMPLOYMENT HISTORY:

Area(s) of concern: ☐Academic ☐Employment
☐No issue reported ☐Other: _____

Last grade completed: _____

Is Client AB2726: ☐ Yes ☐ No

Socio-economic factors:

Occupation: _____

Last date worked: _____

Income source and level: _____

History of volunteer work: _____

MILITARY HISTORY:

Branch: _____ Date of Service: _____

Discharge status: _____

Impact of service/combat history: _____

CULTURAL INFORMATION: *Specific cultural explanations for symptoms of behavior. Include immigration history and acculturation.*

_____

_____

_____

_____

SEXUAL ORIENTATION/GENDER IDENTITY:

Select One:

Heterosexual ☐ Lesbian ☐ Gay Male ☐ Bisexual ☐ Transgender ☐

Questioning ☐ Intersex ☐ Other ☐ Decline to State ☐ Deferred ☐

Clinical Considerations

_____

_____

SOCIAL HISTORY:

Peer/Social Support ☐ None reported ☐ Yes: _____

Sexual concerns: ☐ None reported ☐ Yes: _____

Substance use by peers: ☐ None reported ☐ Yes: _____

Gang affiliations: ☐ None reported ☐ Yes: _____

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

Family/community support system: ☐ None reported ☐ Yes: _____

Religious/spiritual issues: ☐ None reported ☐ Yes: _____

Justice system involvement: ☐ None reported ☐ Yes: _____

Experience of stigma, prejudice, or barriers to accessing services:
☐None reported ☐Yes: _____

HISTORY OF VIOLENCE:

History of domestic violence: ☐ None reported ☐ Yes: _____
History of significant property destruction: ☐ None reported ☐ Yes: _____
History of violence: ☐ None reported ☐ Yes: _____
History of abuse: ☐ None reported ☐ Yes: _____
Abuse reported: ☐ N/A ☐ No ☐ Yes: _____

Experience of traumatic event/s: ☐No ☐Yes ☐Unknown/not reported
If Yes: _____
_____
_____

SUBSTANCE USE INFORMATION:

*History of Substance Use? ☐ No ☐ Yes ☐ Client Declined to Report

(if yes, specify substances used)

Name of Drug	Priority	Method of Admin-istration	Age 1st used	Freq-uency of Use	Days of use in last 30 days	Date of last use	Amount of last use	Amount used on a typical Day	Largest Amount Used in One Day

The client has been advised that smoking is a serious health risk that may lead to lung cancer, cardiovascular disease and the possibility of premature death.
☐Yes ☐N/A

When applicable, outline how substance use impacts current level of functioning:
_____
_____
_____
_____

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

History of substance use treatment:

_____
_____
_____

Recommendation for further substance use treatment: ☐ No ☐ Yes ☐Not applicable

If Yes:

_____
_____
_____

Quadrant: (CCISC – trained program/staff only)

☐ Q. I: Low / Low ☐ Q. II: High / Low
☐ Q III: Low / High ☐ Q. IV: High / High

Stages of Change: (CCISC – trained program/staff only)

☐ Pre-Contemplation ☐Contemplation
☐ Preparation/Determination ☐Action
☐ Maintenance

Gambling:

Have you ever felt the need to bet more and more money? ☐No ☐Yes
Have you ever had to lie to people important to you about how much you gambled? ☐No ☐Yes

MMSE: _____

<u>FUNCTIONAL ASSESSMENT</u>:

Personal care skills:

_____
_____

Activities daily living:

_____
_____

Community living skills:

_____
_____

Social skill:

_____
_____

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

Community educational/work activities:

_____

_____

Somatic safety:

☐Careless smoking ☐AWOL ☐Assault ☐Fire setting
☐ Inappropriate sexual behavior

Basic self-care:
☐ Incontinence ☐Other _____

Housing at risk: ☐ No ☐ Yes

Recent Deaths:

_____

_____

Death Anniversaries:

_____

_____

Decision Maker:
Name: _____ Relationship: _____

Family level of involvement:
☐ Very High ☐ High ☐ Medium ☐ Low

Primary caregiver: _____

Caregiver resources known of/used:

_____

_____

Caregiver burden level: ☐ Mild ☐ Moderate ☐ Severe

ILLNESS MANAGEMENT:

Access to treatment (transportation): ☐ Yes ☐ No

Knowledge of mental health status: ☐ Yes ☐ No

Engagement in treatment: ☐ Yes ☐ No

Knowledge of illness: ☐ Yes ☐ No

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

RECOMMENDATIONS:

Services:

☐ Acute Inpatient ☐ Partial Hospital Day Treatment
☐ Individual/Group Therapy ☐ Case Management
☐ Psycho-social/Educational Activities ☐ Other _____

Living Situation:

☐ Independent Living ☐ Assisted Living
☐ Residential ☐ SNF
☐ Other _____

MENTAL STATUS EXAM

☐ Unable to assess at this time.

Level of Consciousness

☐ Alert ☐ Lethargic ☐ Stuporous

Orientation

☐ Person ☐ Place ☐ Day ☐ Month ☐ Year ☐ Current Situation
☐ All Normal ☐ None

Appearance

☐ Good Hygiene ☐ Poor Hygiene ☐ Malodorous ☐ Disheveled
☐ Reddened Eyes ☐ Normal Weight ☐ Overweight ☐ Underweight

Speech

☐ Normal ☐ Slurred ☐ Loud ☐ Soft ☐ Pressured
☐ Slow ☐ Mute

Thought Process

☐ Coherent ☐ Tangential ☐ Circumstantial ☐ Incoherent ☐ Loose Association

Behavior

☐ Cooperative ☐ Evasive ☐ Uncooperative ☐ Threatening ☐ Agitated ☐ Combative

Affect

☐ Appropriate ☐ Restricted ☐ Blunted ☐ Flat ☐ Labile ☐ Other

Intellect

☐ Average ☐ Below Average ☐ Above Average ☐ Poor Vocabulary
☐ Poor Abstraction ☐ Paucity of Knowledge ☐ Unable to Rate

Mood

☐ Euthymic ☐ Elevated ☐ Euphoric ☐ Irritable ☐ Depressed ☐ Anxious

Memory

☐ Normal ☐ Poor Recent ☐ Poor Remote ☐ Inability to Concentrate
☐ Confabulation ☐ Amnesia

Motor

☐ Age Appropriate/Normal ☐ Slowed/Decreased ☐ Psychomotor Retardation
☐ Hyperactive ☐ Agitated ☐ Tremors ☐ Tics ☐ Repetitive Motions

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

Judgment

☐ Age Appropriate/Normal ☐ Poor ☐ Unrealistic
☐ Fair ☐ Limited ☐ Unable to Rate

Insight

☐ Age Appropriate/Normal ☐ Poor ☐ Fair ☐ Limited ☐ Adequate ☐ Marginal

Command Hallucinations

☐ No ☐ Yes, specify: _____

Auditory Hallucinations

☐ No ☐ Yes, specify: _____

Visual Hallucinations

☐ No ☐ Yes, specify: _____

Tactile Hallucinations

☐ No ☐ Yes, specify: _____

Olfactory Hallucinations

☐ No ☐ Yes, specify: _____

Delusions

☐ No ☐ Yes, specify: _____

Other observations/comments when applicable:

_____
_____
_____
_____
_____

CASE MANAGEMENT (not applicable to all programs)

STRENGTHS/SUPPORT SYSTEMS:

Strengths Model is protected by Copyright (Charles A. Rapp, Ph.D. at the University of Kansas.) Used by San Diego County Mental Health Services with permission.

Daily Living Situation

Current Status *(What is going on today? What is available now?)*

_____
_____

Client's Desires and Aspirations *(What do I want?)*

_____
_____

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

Resources – Social and Personal *(What have I used in the past?)*

_____

_____

Financial/Insurance

Current Status *(What is going on today? What is available now?)*

_____

_____

Client's Desires and Aspirations *(What do I want?)*

_____

_____

Resources – Social and Personal *(What have I used in the past?)*

_____

_____

Vocational/Educational

Current Status *(What is going on today? What is available now?)*

_____

_____

Client's Desires and Aspirations *(What do I want?)*

_____

_____

Resources – Social and Personal *(What have I used in the past?)*

_____

_____

Social Supports

Current Status *(What is going on today? What is available now?)*

_____

_____

Client's Desires and Aspirations *(What do I want?)*

_____

_____

Resources – Social and Personal *(What have I used in the past?)*

_____

_____

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

Health

Current Status *(What is going on today? What is available now?)*

_____

_____

Client's Desires and Aspirations *(What do I want?)*

_____

_____

Resources – Social and Personal *(What have I used in the past?)*

_____

_____

Leisure/Recreational

Current Status *(What is going on today? What is available now?)*

_____

_____

Client's Desires and Aspirations *(What do I want?)*

_____

_____

Resources – Social and Personal *(What have I used in the past?)*

_____

_____

Spiritual/Cultural

Current Status *(What is going on today? What is available now?)*

_____

_____

Client's Desires and Aspirations *(What do I want?)*

_____

_____

Resources – Social and Personal *(What have I used in the past?)*

_____

_____

Client Priorities (*How does the client prioritize the areas above in importance?)*

_____

_____

_____

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

POTENTIAL FOR HARM/RISK ASSESSMENT

*Current Suicidal Ideation? ☐ No ☐Yes ☐Unknown/Refused

Specify plan (vague, passive, imminent):

_____

_____

Access to Means? ☐ No ☐Yes ☐Unknown/Refused

Describe:

_____

_____

Previous Attempts? ☐ No ☐Yes ☐Unknown/Refused

Describe:

_____

_____

Does the client agree not to hurt self or to seek help prior to acting on suicidal impulse?

☐ No ☐Yes ☐Unknown/Refused

Explain:

_____

_____

*Current Homicidal Ideation? ☐ No ☐Yes ☐Unknown/Refused

Specify plan (vague, intent, with/without means):

_____

_____

Identified Victim(s)? ☐ No ☐Yes Tarasoff Warning Indicated? ☐ No ☐Yes

Reported To: _____ Date: _____

Victim(s) name and contact information (Tarasoff Warning Details):

_____

_____

_____

Acts of Property Damage? ☐ Yes ☐ No Most Recent Date: _____

_____

Gravely Disabled? ☐ Yes ☐ No

_____

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

*Current Domestic Violence: ☐ No ☐Yes

Describe situation:

_____

_____

_____

Child/Adult Protective Services Notification Indicated? ☐ No ☐Yes

Reported to: _____ Date: _____

Specify Domestic Violence Plan (include Child/Adult Protective Services information):

_____

_____

_____

Urine Drug Screen: ☐ Positive ☐ Negative ☐ Pending ☐ Refused ☐ N/A

_____

_____

Breathalyzer: ☐ Positive ☐ Negative ☐ Pending ☐ Refused ☐ N/A

_____

_____

Comments Regarding Factors Increasing Risk: _____

_____

_____

Justice System Involvement? ☐ Yes ☐ No ☐Unknown

If yes, describe recent arrests, probation, sex offender information, et cetera:

_____

_____

_____

ASSESSMENT OF STRENGTHS

*I have considered the client's strengths: ☐ Yes ☐ No

If no, explain:

Check all that apply

Optimism/Hope	☐ Yes	☐ No	Hobbies/Special Interests	☐ Yes	☐ No
Sense of Meaning	☐ Yes	☐ No	Goal Directed/Motivated	☐ Yes	☐ No
Faith/Spirituality	☐ Yes	☐ No	Compassion/Altruism	☐ Yes	☐ No
Empathy/Caring	☐ Yes	☐ No	Stable Family Life	☐ Yes	☐ No
Resourcefulness	☐ Yes	☐ No	Communication	☐ Yes	☐ No
Self-Efficacy/Mastery	☐ Yes	☐ No	Internal Locus of Control	☐ Yes	☐ No
Academic History	☐ Yes	☐ No	Sense of Empowerment	☐ Yes	☐ No

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

Daily Living Skills	☐ Yes	☐ No	Work History	☐ Yes	☐ No
Self-Awareness	☐ Yes	☐ No	Living Environment	☐ Yes	☐ No
Flexibility	☐ Yes	☐ No	Positive Identity	☐ Yes	☐ No
Sense of Humor	☐ Yes	☐ No	Adaptive Distancing/Resistance	☐ Yes	☐ No
Responsiveness	☐ Yes	☐ No	Planning	☐ Yes	☐ No
Support System	☐ Yes	☐ No	Insight/Critical Thinking	☐ Yes	☐ No
Open to Change	☐ Yes	☐ No	Previous Positive Experience in Treatment	☐ Yes	☐ No
			Utilizes Agreed-Upon Treatment Recommendations	☐ Yes	☐ No

AREAS OF NEED

List of Problems: (Check all that apply)

Abuse/Addiction: Substance/Non-Substance	☐ Yes	☐ No
Basic Needs: Food, Clothing, Shelter	☐ Yes	☐ No
Education	☐ Yes	☐ No
Emotional-Behavioral/Psychiatric	☐ Yes	☐ No
Family Stress	☐ Yes	☐ No
Financial	☐ Yes	☐ No
Identity Issues: Cultural/Gender	☐ Yes	☐ No
Intimate Relationships	☐ Yes	☐ No
Lack of Physical Health Care	☐ Yes	☐ No
Legal	☐ Yes	☐ No
Meaningful Role (tied to self-determination)	☐ Yes	☐ No
Neglect/Abuse	☐ Yes	☐ No
Neurological/Brain Impairment	☐ Yes	☐ No
Physical Health Problems	☐ Yes	☐ No
Potential for Harm: Self/Others	☐ Yes	☐ No
Social Functioning	☐ Yes	☐ No
Spiritual	☐ Yes	☐ No
Stress	☐ Yes	☐ No
Trauma	☐ Yes	☐ No
Vocational/Employment	☐ Yes	☐ No

DIAGNOSIS If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Behavioral Health Assessment.

CLINICAL CONCLUSION: *Justification for diagnosis and medical necessity. Summarize and integrate all information gathered from other sources to render clinical judgments regarding intensity, length of treatment and recommendations for services. Clearly state those emotional or behavioral symptoms that interfere with normal functioning. Include evaluation of client's ability and willingness to solve the presenting problems, addressing both mental health and substance issues from an integrated perspective.*

_____

_____

_____

_____

_____

_____

_____

_____

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

_____
_____
_____
_____
_____
_____
_____
_____

Medical Necessity Met: ☐ No ☐ Yes

When "No," note date NOA-A issued [Medi-Cal clients only]: _____

CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE? ☐Yes Date: _____

Local mental health program shall inform Clients receiving mental health services, including parents or guardians of children / adolescents, verbally or in writing that:

☐ Acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services;

☐ They retain the right to access other Medi-Cal or Short Doyle/Medi-Cal reimbursable services and have the right to request a change of provider, staff person, therapist, and/or case manager.

☐ **Guide to Medi-Cal Mental Health Services was explained and offered on: _____**

☐ **Grievance and Appeal Process explained and Brochure with form fill and envelope offered on: _____**

☐ **Provider List explained and offered on: _____**

☐ **Mental Health Plan's Notice of Privacy Practices (NPP) was offered on: _____**

☐ **Language/Interpretation services availability reviewed and offered when applicable on: _____**

☐ **Advanced Directive brochure was offered on: _____**

Signature of Clinician Requiring Co-signature:

_____ _____

Signature Date

_____ _____

Printed Name Anasazi ID number:

Client Name: _____ Case # _____

Assessment Date _____ Program Name _____

***Signature of Clinician Completing/Accepting the Assessment:**

_____ _____

Signature Date

_____ _____

Printed Name Anasazi ID number:

Signature of Staff Entering Information (if different from above):

_____ _____

Signature Date

_____ _____

Printed Name Anasazi ID number

San Diego County Mental Health Services
BEHAVIORAL HEALTH ASSESSMENT - CHILDREN
Instructions

CLIENT NAME: Required Field

CASE #- Required Field.

ASSESSMENT DATE – Required Field.

PROGRAM NAME- Required Field.

SOURCE OF INFORMATION- Required Field. Select from the Source of information Table below. Include the ID and Description in your documentation. If "Other" is selected, please provide information.

ID	Description	ID	Description
AB2726 Asr	AB2726 Assessor	**Other**	Other
ADS Prov	ADS Recovery Provider	**Parent LG**	Parent/Legal Guardian
Client	Client	**Prev Asst**	Previous Assessment
Case Mnager	Case Manager	**Probation/Parole Officer**	Probation/Parole Officer
Conservatr	Conservator	**Soc Worker**	Social Worker
Family	Family	**Teacher**	Teacher/School
Fos Parent	Foster Parent	**Therapist**	Therapist
MD	MD		

REPORTS REVIEWED**:** Enter any reports used as part of the assessment.

REFERRAL SOURCE: Enter name of referral source here.

PRESENTING PROBLEMS/NEEDS: Required field. Write in the area provided, using the help text as a guide.

PAST PSYCHIATRIC HISTORY: **Required field.** Write in the area provided, using the help text as a guide.

MEDICAL HISTORY: The "Does client have a Primary Care Physician?" **is Required**. The "Physical Health Issues" prompt **is Required**. The "Allergies and adverse medication reactions" prompt **is Required**.

For the rest of this section, enter the appropriate check marks and text as indicated.
For the "Healing and Health" section: Write in the area provided, using the help text as a guide.

HISTORY OF EARLY INTERVENTION: Check the appropriate boxes as indicated. Describe results in the space provided.

FAMILY HISTORY:

LIVING ARRANGEMENT: **A Required Field.**

Select from the Living Arrangement Table below. Include the ID and Description in your documentation. If "Other" is selected, please provide information.

Living Arrangement		
A-House or Apartment B-House or Apt with Support C-House or Apt with Daily Supervision Independent Living Facility D-Other Supported Housing Program E-Board & Care – Adult F-Residential Tx/Crisis Ctr – Adult	G-Substance Abuse Residential Rehab Ctr H-Homeless/In Shelter I-MH Rehab Ctr (Adult Locked) J-SNF/ICF/IMD K-Inpatient Psych Hospital L-State Hospital M-Correctional Facility	O-Other R-Foster Home-Child S-Group Home-Child (Level 1-12) T-Residential Tx Ctr-Child (Level 13-14) U-Unknown V-Comm Tx Facility (Child Locked) W- Children's Shelter

THOSE LIVING IN THE HOME WITH THE CLIENT: List the names and relationship to client, and other pertinent information, in the space provided.

HAVE ANY RELATIVES EVER HAD ANY OF THE FOLLOWING CONDITIONS: For each listed condition, enter information from the family members table, if applicable, in the spaces provided. Expand below when applicable. Leave blank if there are none:

ID	DESCRIPTION	ID	DESCRIPTION	ID	DESCRIPTION
Aunt Bio	Aunt – Biological	**Fath InLaw**	Father – In-Law	**Niece Bio**	Niece – Biological
Aunt NoBio	Aunt – Non-biological	**Fath Step**	Father-Step	**Niece NBio**	Niece – Non-biological
Bro Adop	Brother – Adopted	**Gdaug Bio**	Granddaughter – Biological	**Other**	Other
Bro Bio	Brother – Biological	**GDaug Nbio**	Granddaughter – Non-biological	**Sis Adop**	Sister-Adopted
Bro Foster	Brother – Foster	**GrFa Bio**	Grandfather – Biological	**Sis Bio**	Sister-Biological
Bro InLaw	Brother – In-Law	**GrFa NBio**	Grandfather – Non-biological	**Sis Foster**	Sister – Foster
Bro Step	Brother – Step	**GrMo Bio**	Grandmother – Biological	**Sis InLaw**	Sister – In-Law
Cous Bio	Cousin – Biological	**GrMo Nbio**	Grandmother – Non-biological	**Sis Step**	Sister – Step
Cous Nbio	Cousin – Non-biological	**GrSon Bio**	Grandson – Biological	**Son Adopt**	Son-Adopted
Daug Adopt	Daughter – Adopted	**GrSon Nbio**	Grandson – Non-biological	**Son Bio**	Son – Biological
Daug Bio	Daughter – Biological	**Husband**	Husband	**Son Foster**	Son – Foster
Daug Foster	Daughter – Foster	**Mother Ado**	Mother – Adopted	**Son in Law**	Son – In-Law
Daug InLaw	Daughter – In-Law	**Mother Bio**	Mother – Biological	**Son Step**	Son – Step
Daug Step	Daughter – Step	**Mother Fos**	Mother – Foster	**Signif Oth**	Significant Other
Dom Partner	Domestic Partner	**Mo In Law**	Mother – In-Law	**Sig Supp**	Significant Support Person
Fath Adop	Father – Adopted	**Mo Step**	Mother – Step	**Uncle Bio**	Uncle - Biological
Fath Bio	Father – Biological	**Neph Bio**	Nephew – Biological	**Uncl NBio**	Uncle – Non-biological
Fath Fost	Father – Foster	**Neph NBio**	Nephew – Non-biological	**Wife**	Wife

Include relevant family information impacting the client: (Further explain family member's involvement in substance use)

EDUCATIONAL/EMPLOYMENT HISTORY: Check all "Areas of Concern" boxes that apply. Complete the other prompts as applicable.

CULTURAL INFORMATION: Write in the area provided.

SEXUAL ORIENTATION/GENDER IDENTITY: Select from choices available.

SOCIAL HISTORY: Check all boxes as applicable. Give explanations for all "yes" answers. For Family/Community support system, include alternate relationship support, if any, for mental health and/or substance use such as supportive/community groups, AA/NA. For Religious/Spiritual issues, document if religion/spirituality is important in a client's life and/or a source of strength. Describe persons and practices, and how they are important. For Justice System Involvement, describe what system, extent, probation/parole, time served, etc.

HISTORY OF VIOLENCE: Check all boxes as applicable. Give explanations for all "yes" answers

SUBSTANCE USE INFORMATION: This is Required. Check all boxes as applicable, including the CRAFFT. Select "No", "Yes", or "Client Declined to Report" as it applies to the client. If the client indicates "yes", in the space provided, document name, frequency, amount and other relevant information about the substances the client reports using.

Educate the client regarding the effects of smoking by reading the following statement: “Smoking is a serious health risk that may lead to lung cancer, cardiovascular disease and the possibility of premature death.” Indicate that you have provided this advisement by selecting the “Yes” check box.

MENTAL STATUS, POTENTIAL FOR HARM, STRENGTHS, AREAS OF NEED: Provide answers for items in these domains by selecting the appropriate check boxes or entering requested text in the spaces provided. Consult form Help Texts as available.

DIAGNOSIS
If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Behavioral Health Assessment.

CLINICAL CONCLUSION: Document justification and medical necessity in the space provided, using the form’s Help Text as a guide.

RECOMMENDATIONS/MEDICAL NECESSITY MET: Check the appropriate boxes, as indicated.

CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE: Provide the dates and check each item as completed.

Signatures: The clinician completing the form will sign his/her name with credential on the signature line, and print their name on the second line. Date and Anasazi Staff ID number are documented at the appropriate prompts.

When a clinician needs a co-signature, a qualified clinician will sign, print name, date and enter Anasazi Staff ID as indicated. Refer to Scope of Practice to identify who needs a co-signature.

San Diego County Mental Health Services
BEHAVIORAL HEALTH ASSESSMENT – CHILDREN

***Client Name**: _____ ***Case #:** _____

***Assessment Date** _____ * **Program Name**: _____

***SOURCE OF INFORMATION** (*Select from Source of Information Table located in the Instructions sheet)*

_____

If a source other than listed on the "Source of Information" Table, specify _____
_____

Reports Reviewed: _____

Referral Source:_____

***PRESENTING PROBLEMS/NEEDS** (*Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and history of present illness. Summary of client's request for services including client's most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors; include experiences of stigma and prejudice, if any)*
_____
_____
_____
_____

***PAST PSYCHIATRIC HISTORY** (*Previous history of symptoms and/or mental health treatment. Describe in chronological order - where, when, and length of time. Include dates and providers related to any prior psychiatric treatment, history, traumatic and/or significant events, and/or trauma related to treatment. Include the most recent periods of stability and the characteristics of those periods)*

_____
_____
_____
_____

MEDICAL HISTORY:

*Does client have a Primary Care Physician? ☐No ☐Yes ☐ Unknown
If No, has client been advised to seek primary care? ☐No ☐Yes
Primary Care Physician: _____
Phone Number:_____
Seen within the last: ☐ 6 months ☐ 12 months ☐ Other:_____
Hospital of choice (physical health):_____
Been seen for the following (provide dates of last exam):
Dental exam:_____
Hearing exam:_____
Vision exam:_____
*Physical Health issues: ☐None at this time ☐Yes
If Yes, specify:_____

Is condition followed by Primary Care Physician? ☐No ☐Yes ☐N/A
Physical health problems affecting mental health functioning:_____
_____

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

Head injuries: ☐No ☐Yes
If Yes, specify:_____
_____

Medical and/or adaptive devices:_____

Hearing seems to be normal: ☐No ☐Yes
Hearing has been tested: ☐No ☐Yes If Yes, when? _____
Where? _____ Results? _____

Vision seems normal: ☐No ☐Yes Wears glasses: ☐No ☐Yes
Head circumference:_____ Height: _____ Weight:_____

Significant Developmental Information (when applicable):_____
_____

*Allergies and adverse medication reactions: ☐No ☐Unknown/Not Reported ☐ Yes
If Yes, specify:_____
_____

Medications (Active and Current Inactivations):

Med	Start Date	Is Date Estimated Y or N	Dosage/ Frequency	Amt. Prescribed	Target Sxs	Taken as Pre-scribed? Y, N or Unk	Prescribing Physician Name	**	Refills	Stop Date	Reason for Stopping

***Physician Type**: 1. current psychiatrist (out of network) 2. current PCP 3. previous psychiatrist (out of network) 4. previous PCP*

Other prescription medications: ☐None ☐Yes:_____
_____

Herbals/Dietary Supplements/Over the counter medications: ☐None ☐Yes:_____
_____

Healing and Health: (*Alternative healing practices and beliefs. Apart from mental health professionals, who or what helps client deal with disability/illness and/or to address substance use issues? Describe):*
_____
_____

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

HISTORY OF EARLY INTERVENTION:

☐ Speech-Language ☐ Occupational ☐ Behavioral
☐ Physical ☐ Hearing ☐ Counseling
☐ Parent Training ☐ Educational ☐ Developmental
☐ Psychological
☐ Describe Results: _____
_____

FAMILY HISTORY:

*Living Arrangement: *Select from Living Arrangement table listed in the Instructions Sheet*
_____
_____

Those living in the home with client:_____
_____

Have any relatives ever had any of the following conditions
(Select from Relatives table listed in the Instructions Sheet) Expand below if applicable.

Substance abuse or addiction:_____
Other addictions: _____
Suicidal thoughts, attempts:_____
Emotional/mental health issues:_____
Mental retardation:_____
Developmental delays: _____
Arrests: _____

Include relevant family information impacting the client:_____
_____
_____

EDUCATIONAL/EMPLOYMENT HISTORY:

Area(s) of concern: ☐Academic ☐Employment
☐No issue reported ☐Other:_____

Last grade completed: _____

Is Client AB2726: ☐ Yes ☐ No

Special Education Class: ☐ N/A
☐ Current:_____
☐ Past:_____
☐ Failed the following grade(s): _____

Client has an active IEP: ☐ No ☐ Yes

Socio-economic factors:
Occupation:_____
Last date worked: _____
Income source and level: _____

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

History of volunteer work: _____

CULTURAL INFORMATION: (*Specific cultural explanations for symptoms of behavior. Include immigration history and acculturation)*

_____

_____

_____

SEXUAL ORIENTATION/GENDER IDENTITY:

Select One:

Heterosexual ☐ Lesbian ☐ Gay Male ☐ Bisexual ☐ Transgender ☐

Questioning ☐ Intersex ☐ Other ☐ Decline to State ☐ Deferred ☐

SOCIAL HISTORY:

Peer/Social Support ☐ None reported ☐ Yes:_____

Sexual concerns: ☐ None reported ☐ Yes:_____

Substance use by peers: ☐ None reported ☐ Yes:_____

Gang affiliations: ☐ None reported ☐ Yes: _____

_____

Family/community support system: ☐ None reported ☐ Yes:_____

_____

Religious/spiritual issues: ☐ None reported ☐ Yes:_____

_____

Justice system involvement: ☐ None reported ☐ Yes:_____

_____

Experience of stigma, prejudice, or barriers to accessing services:

☐ None reported ☐Yes:_____

_____

HISTORY OF VIOLENCE:

History of domestic violence: ☐ None reported ☐ Yes:_____

_____

History of significant property destruction: ☐ None reported ☐ Yes:_____

_____

History of violence: ☐ None reported ☐ Yes:_____

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

_____

History of abuse: ☐ None reported ☐ Yes:_____

_____

Abuse reported: ☐ N/A ☐ No ☐ Yes: _____

Experience of traumatic event/s: ☐ No ☐ Yes ☐ Unknown/not reported
If Yes: _____

SUBSTANCE USE INFORMATION:

☐ Not applicable to client

CRAFFT (Administer measure by providing handout or reading questions verbatim, in order and without interpretation)

HAVE YOU EVER?		Yes	No
1.	Have you ever ridden in a CAR driven by someone (including yourself) who was high or had been using alcohol or drugs?		
2.	Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?		
3.	Do you ever use alcohol or drugs while you are by yourself ALONE?		
4.	Do you ever FORGET things you did while using alcohol or drugs?		
5.	Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?		
6.	Have you ever gotten into TROUBLE while you were using alcohol or drugs?		

2 or more "Yes" answers suggests dual diagnosis issues and should be explored further. **TOTAL: _____**

*History of Substance Use? ☐ No ☐ Yes ☐ Client Declined to Report

(if yes, specify substances used)

Name of Drug	**Priority**	**Method of Admin-istration**	**Age 1st used**	**Freq-uency of Use**	**Days of use in last 30 days**	**Date of last use**	**Amount of last use**	**Amount used on a typical Day**	**Largest Amount Used in One Day**

The client has been advised that smoking is a serious health risk that may lead to lung cancer, cardiovascular disease and the possibility of premature death.

☐Yes ☐N/A

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

When applicable, outline how substance use impacts current level of functioning:

_____
_____
_____
_____

History of substance use treatment:

_____
_____
_____

Recommendation for further substance use treatment: ☐ No ☐ Yes ☐Not applicable

If Yes:

_____
_____
_____

Quadrant: (CCISC – trained program/staff only)

☐ Q. I: Low / Low ☐ Q. II: High / Low
☐ Q III: Low / High ☐ Q. IV: High / High

Stages of Change: (CCISC – trained program/staff only)

☐ Pre-Contemplation ☐Contemplation
☐Preparation/Determination ☐Action
☐ Maintenance

Gambling:

Have you ever felt the need to bet more and more money? ☐No ☐Yes
Have you ever had to lie to people important to you about how much you gambled? ☐No ☐Yes

EVALUATION RESULTS:_____
_____
_____
_____
_____

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

MENTAL STATUS EXAM

☐ Unable to assess at this time.

Level of Consciousness

☐ Alert ☐ Lethargic ☐ Stuporous

Orientation

☐ Person ☐ Place ☐ Day ☐ Month ☐ Year ☐ Current Situation

☐ All Normal ☐ None

Appearance

☐ Good Hygiene ☐ Poor Hygiene ☐ Malodorous ☐ Disheveled

☐ Reddened Eyes ☐ Normal Weight ☐ Overweight ☐ Underweight

Speech

☐ Normal ☐ Slurred ☐ Loud ☐ Soft ☐ Pressured

☐ Slow ☐ Mute

Thought Process

☐ Coherent ☐ Tangential ☐ Circumstantial ☐ Incoherent ☐ Loose Association

Behavior

☐ Cooperative ☐ Evasive ☐ Uncooperative ☐ Threatening ☐ Agitated ☐ Combative

Affect

☐ Appropriate ☐ Restricted ☐ Blunted ☐ Flat ☐ Labile ☐ Other

Intellect

☐ Average ☐ Below Average ☐ Above Average ☐ Poor Vocabulary

☐ Poor Abstraction ☐ Paucity of Knowledge ☐ Unable to Rate

Mood

☐ Euthymic ☐ Elevated ☐ Euphoric ☐ Irritable ☐ Depressed ☐ Anxious

Memory

☐ Normal ☐ Poor Recent ☐ Poor Remote ☐ Inability to Concentrate

☐ Confabulation ☐ Amnesia

Motor

☐ Age Appropriate/Normal ☐ Slowed/Decreased ☐ Psychomotor Retardation

☐ Hyperactive ☐ Agitated ☐ Tremors ☐ Tics ☐ Repetitive Motions

Judgment

☐ Age Appropriate/Normal ☐ Poor ☐ Unrealistic

☐ Fair ☐ Limited ☐ Unable to Rate

Insight

☐ Age Appropriate/Normal ☐ Poor ☐ Fair ☐ Limited ☐ Adequate ☐ Marginal

Command Hallucinations

☐ No ☐ Yes, specify: _____

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

Auditory Hallucinations

☐ No ☐ Yes, specify: _____

Visual Hallucinations

☐ No ☐ Yes, specify: _____

Tactile Hallucinations

☐ No ☐ Yes, specify: _____

Olfactory Hallucinations

☐ No ☐ Yes, specify: _____

Delusions

☐ No ☐ Yes, specify: _____

Other observations/comments when applicable :

_____

_____

_____

_____

POTENTIAL FOR HARM/RISK ASSESSMENT

*Current Suicidal Ideation? ☐ No ☐Yes ☐Unknown/Refused

Specify plan (vague, passive, imminent):_____

_____

Access to Means? ☐ No ☐Yes ☐Unknown/Refused

Describe:_____

_____

Previous Attempts? ☐ No ☐Yes ☐Unknown/Refused

Describe:_____

_____

Does the client agree not to hurt self or to seek help prior to acting on suicidal impulse?

☐ No ☐Yes ☐Unknown/Refused

Explain:_____

_____

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

*Current Homicidal Ideation? ☐ No ☐Yes ☐Unknown/Refused

Specify plan (vague, intent, with/without means):_____

_____

Identified Victim(s)? ☐ No ☐Yes Tarasoff Warning Indicated? ☐ No ☐Yes

Reported To:_____ Date:_____

Victim(s) name and contact information (Tarasoff Warning Details):_____

_____

_____

Acts of Property Damage? ☐ Yes ☐ No Most Recent Date: _____

_____

Gravely Disabled? ☐ Yes ☐ No

_____

_____

_____

*Current Domestic Violence: ☐ No ☐Yes

Describe Situation: _____

_____

_____

Child/Adult Protective Services Notification Indicated? ☐ No ☐Yes

Reported To:_____ Date:_____

Specify Domestic Violence Plan (include Child/Adult Protective Services Information):_____

_____

_____

Urine Drug Screen: ☐ Positive ☐ Negative ☐ Pending ☐ Refused ☐ N/A

_____

_____

Breathalyzer: ☐ Positive ☐ Negative ☐ Pending ☐ Refused ☐ N/A

_____

_____

Comments Regarding Factors Increasing Risk:_____

_____

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

_____

Justice System Involvement? ☐ Yes ☐ No ☐Unknown

If yes, describe recent arrests, probation, sex offender information, et cetera:_____

_____

_____

ASSESSMENT OF STRENGTHS

*I have considered the client's strengths: ☐ Yes ☐ No

If no, explain:

Check all that apply

Optimism/Hope	☐ Yes	☐ No	Hobbies/Special Interests	☐ Yes	☐ No
Sense of Meaning	☐ Yes	☐ No	Goal Directed/Motivated	☐ Yes	☐ No
Faith/Spirituality	☐ Yes	☐ No	Compassion/Altruism	☐ Yes	☐ No
Empathy/Caring	☐ Yes	☐ No	Stable Family Life	☐ Yes	☐ No
Resourcefulness	☐ Yes	☐ No	Communication	☐ Yes	☐ No
Self-Efficacy/Mastery	☐ Yes	☐ No	Internal Locus of Control	☐ Yes	☐ No
Academic History	☐ Yes	☐ No	Sense of Empowerment	☐ Yes	☐ No
Daily Living Skills	☐ Yes	☐ No	Work History	☐ Yes	☐ No
Self-Awareness	☐ Yes	☐ No	Living Environment	☐ Yes	☐ No
Flexibility	☐ Yes	☐ No	Positive Identity	☐ Yes	☐ No
Sense of Humor	☐ Yes	☐ No	Adaptive Distancing/Resistance	☐ Yes	☐ No
Responsiveness	☐ Yes	☐ No	Planning	☐ Yes	☐ No
Support System	☐ Yes	☐ No	Insight/Critical Thinking	☐ Yes	☐ No
Open to Change	☐ Yes	☐ No	Previous Positive Experience in Treatment	☐ Yes	☐ No
			Utilizes Agreed-Upon Treatment Recommendations	☐ Yes	☐ No

AREAS OF NEED

List of Problems: (Check all that apply)

Abuse/Addiction: Substance/Non-Substance	☐ Yes	☐ No
Basic Needs: Food, Clothing, Shelter	☐ Yes	☐ No
Education	☐ Yes	☐ No
Emotional-Behavioral/Psychiatric	☐ Yes	☐ No
Family Stress	☐ Yes	☐ No
Financial	☐ Yes	☐ No
Identity Issues: Cultural/Gender	☐ Yes	☐ No
Intimate Relationships	☐ Yes	☐ No
Lack of Physical Health Care	☐ Yes	☐ No
Legal	☐ Yes	☐ No
Meaningful Role (tied to self-determination)	☐ Yes	☐ No
Neglect/Abuse	☐ Yes	☐ No
Neurological/Brain Impairment	☐ Yes	☐ No
Physical Health Problems	☐ Yes	☐ No

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

Potential for Harm: Self/Others	☐ Yes	☐ No
Social Functioning	☐ Yes	☐ No
Spiritual	☐ Yes	☐ No
Stress	☐ Yes	☐ No
Trauma	☐ Yes	☐ No
Vocational/Employment	☐ Yes	☐ No

DIAGNOSIS If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Behavioral Health Assessment.

CLINICAL CONCLUSION: (*Justification for diagnosis and medical necessity. Summarize and integrate all information gathered from other sources to render clinical judgments regarding intensity, length of treatment and recommendations for services. Clearly state those emotional or behavioral symptoms that interfere with normal functioning. Include evaluation of client's ability and willingness to solve the presenting problems, addressing both mental health and substance issues from an integrated perspective)*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Medical Necessity Met: ☐ No ☐ Yes

When "No," note date NOA-A issued [Medi-Cal clients only]: _____

CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE? ☐Yes Date:

Local mental health program shall inform Clients receiving mental health services, including parents or guardians of children / adolescents, verbally or in writing that:

☐ Acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services;

☐ They retain the right to access other Medi-Cal or Short Doyle/Medi-Cal reimbursable services and have the right to request a change of provider, staff person, therapist, and/or case manager.

☐ **Guide to Medi-Cal Mental health Services was explained and offered on: _____**

☐ **Grievance and Appeal Process explained and Brochure with form fill & envelope offered on: _____**

☐ **Provider List explained and offered on: _____**

☐ **Mental Health Plan's Notice of Privacy Practices (NPP) was offered on: _____**

☐ **Language/Interpretation services availability reviewed and offered when applicable on: _____**

☐ **Advanced Directive brochure was offered on: _____**

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

Signature of Clinician Requiring Co-signature:

_____ _____
Signature Date

_____ _____
Printed Name Anasazi ID number

Signature of Clinician Completing/Accepting the Assessment:

_____ _____
Signature Date

_____ _____
Printed Name Anasazi ID number

Signature of Staff Entering Information (if different from above):

_____ _____
Signature Date

_____ _____
Printed Name Anasazi ID number

BEHAVIORAL HEALTH ASSESSMENTS - EHR

2012

(EMERGENCY SCREENING UNIT - ESU)

WHEN: At the time a client is assessed for need for hospitalization or any other crisis situation. When significant changes occur the assessment may be revised by opening a new assessment, adding the updated information, and final approving the assessment.

ON WHOM: Every client who receives a Crisis assessment.

COMPLETED BY: Staff delivering services within scope of practice. Must be signed by:

Physician,
Licensed/Waivered Psychologist,
Licensed/Registered/Waivered Social Worker,
Licensed/Registered/Waivered Marriage Family Therapist, or
Registered Nurse.
Trainee can complete but must be co-signed by one of the above.

Co-signatures must be completed for the Behavioral Health Assessment to be final approved.

MODE OF COMPLETION: Data must be entered into the Electronic Health Record.

REQUIRED ELEMENTS: All clinically appropriate elements should be completed.

NOTE: Every assessment within the EHR must be completed and final approved in a timely manner. When it is not completed and final approved (red locked), the system will prevent other servers from launching any assessments that contain shared fields. An assessment that is not final approved (status is “open green locked”) is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Assessments are not viewed as complete and active until the assessment is final approved (red locked).

San Diego County Mental Health Services
BEHAVIORAL HEALTH ASSESSMENT – ESU
Instructions

CLIENT NAME - Required Field.
CASE # - Required Field.
ASSESSMENT DATE – Required Field**.**
PROGRAM NAME- Required Field.

SOURCE OF INFORMATION- Required Field. Select from the Source of information Table below. Include the ID and Description in your documentation. If "Other" is selected, please provide information.

ID	Description	ID	Description
AB2726 Asr	AB2726 Assessor	**Other**	Other
ADS Prov	ADS Recovery Provider	**Parent LG**	Parent/Legal Guardian
Case Mnager	Case Manager	**Parole**	Parole Officer
Client	Client	**Prev Asst**	Previous Assessment
Conservatr	Conservator	**Probation**	Probation Officer
Family	Family	**Soc Worker**	Social Worker
Fos Parent	Foster Parent	**Teacher**	Teacher/School
MD	MD	**Therapist**	Therapist

INTERPRETER USED: Chose the appropriate check box as applicable.

REPORTS REVIEWED**:** Enter any reports used as part of the assessment.

AGENCY INVOLVEMENT: Enter information in the space provided, using the Help Text as a guide.

REFERRAL SOURCE: Enter name of referral source here.

PRESENTING PROBLEMS/NEEDS: Required field. Write in the area provided, using the help text as a guide.

PAST PSYCHIATRIC HISTORY: **Required field.** Write in the area provided, using the help text as a guide.

MEDICAL HISTORY: The "Does client have a Primary Care Physician?" **is Required**. The "Physical Health Issues" prompt **is Required**. The Allergies and adverse medication reactions" prompt **is Required.**

MEDICATIONS: In the space provided, enter current medications, dosages and other pertinent information.

For the rest of this section, enter the appropriate check marks and text as indicated.
For the "Healing and Health" section: Write in the area provided, using the help text as a guide.

VITAL SIGNS: Enter the appropriate values in the spaces provided.

PAIN: Document using the check-boxes and provided spaces as requested.

FAMILY HISTORY:

LIVING ARRANGEMENT: **A Required Field**.

Select from the Living Arrangement Table below. Include the ID and Description in your documentation. If "Other" is selected, please provide information.
.

Living Arrangement		
A-House or Apartment B-House or Apt with Support C-House or Apt with Daily Supervision Independent Living Facility D-Other Supported Housing Program E-Board & Care – Adult F-Residential Tx/Crisis Ctr – Adult	G-Substance Abuse Residential Rehab Ctr H-Homeless/In Shelter I-MH Rehab Ctr (Adult Locked) J-SNF/ICF/IMD K-Inpatient Psych Hospital L-State Hospital M-Correctional Facility	O-Other R-Foster Home-Child S-Group Home-Child (Level 1-12) T-Residential Tx Ctr-Child (Level 13-14) U-Unknown V-Comm Tx Facility (Child Locked) W- Children's Shelter

THOSE LIVING IN THE HOME WITH THE CLIENT: List the names and relationship to client, and other pertinent information, in the space provided.

HAVE ANY RELATIVES EVER HAD ANY OF THE FOLLOWING CONDITIONS: For each listed condition, enter information from the family members table, if applicable, in the spaces provided. Leave blank if there are none:

ID	DESCRIPTION	ID	DESCRIPTION	ID	DESCRIPTION
Aunt Bio	Aunt – Biological	**Fath InLaw**	Father – In-Law	**Niece Bio**	Niece – Biological
Aunt NoBio	Aunt – Non-biological	**Fath Step**	Father-Step	**Niece NBio**	Niece – Non-biological
Bro Adop	Brother – Adopted	**Gdaug Bio**	Granddaughter – Biological	**Other**	Other
Bro Bio	Brother – Biological	**GDaug Nbio**	Granddaughter – Non-biological	**Sis Adop**	Sister-Adopted
Bro Foster	Brother – Foster	**GrFa Bio**	Grandfather – Biological	**Sis Bio**	Sister-Biological
Bro InLaw	Brother – In-Law	**GrFa NBio**	Grandfather – Non-biological	**Sis Foster**	Sister – Foster
Bro Step	Brother – Step	**GrMo Bio**	Grandmother – Biological	**Sis InLaw**	Sister – In-Law
Cous Bio	Cousin – Biological	**GrMo Nbio**	Grandmother – Non-biological	**Sis Step**	Sister – Step
Cous Nbio	Cousin – Non-biological	**GrSon Bio**	Grandson – Biological	**Son Adopt**	Son-Adopted
Daug Adopt	Daughter – Adopted	**GrSon Nbio**	Grandson – Non-biological	**Son Bio**	Son – Biological
Daug Bio	Daughter – Biological	**Husband**	Husband	**Son Foster**	Son – Foster
Daug Foster	Daughter – Foster	**Mother Ado**	Mother – Adopted	**Son in Law**	Son – In-Law
Daug InLaw	Daughter – In-Law	**Mother Bio**	Mother – Biological	**Son Step**	Son – Step
Daug Step	Daughter – Step	**Mother Fos**	Mother – Foster	**Signif Oth**	Significant Other
Dom Partner	Domestic Partner	**Mo In Law**	Mother – In-Law	**Sig Supp**	Significant Support Person
Fath Adop	Father – Adopted	**Mo Step**	Mother – Step	**Uncle Bio**	Uncle - Biological
Fath Bio	Father – Biological	**Neph Bio**	Nephew – Biological	**Uncl NBio**	Uncle – Non-biological
Fath Fost	Father – Foster	**Neph NBio**	Nephew – Non-biological	**Wife**	Wife

Include relevant family information impacting the client:

EDUCATIONAL/EMPLOYMENT HISTORY: Check all "Areas of Concern" boxes that apply. Complete the other prompts as applicable.

In the space provided, document any other important educational/vocational information, using the Help Text as a guide.

CULTURAL INFORMATION: Document cultural explanations for symptoms in the space provided, using the Help Text as a guide.

SOCIAL HISTORY: Check all boxes as applicable. Give explanations for all "yes" answers. For Family/Community support system, include alternate relationship support, if any, for mental health and/or substance use such as supportive/community groups, AA/NA. For Religious/Spiritual issues, document if religion/spirituality is important in a

client's life and/or a source of strength. Describe persons and practices, and how they are important. For Justice System Involvement, describe what system, extent, probation/parole, time served, etc.

HISTORY OF VIOLENCE: Check all boxes as applicable. Give explanations for all "yes" answers

SUBSTANCE USE INFORMATION: This is Required. Check all boxes as applicable, including the CRAFFT.

Educate the client regarding the effects of smoking by reading the following statement: "Smoking is a serious health risk that may lead to lung cancer, cardiovascular disease and the possibility of premature death." Indicate you have provided this advisement by selecting the "Yes" check box.

Complete the rest of this section by entering the requested text or selecting the appropriate check boxes.

MENTAL STATUS, POTENTIAL FOR HARM, STRENGTHS, AREAS OF NEED: Provide answers for items in these domains by selecting the appropriate check boxes or entering requested text in the spaces provided. Consult form Help Texts as available.

DIAGNOSIS
If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Behavioral Health Assessment.

CLINICAL CONCLUSION: Document justification and medical necessity in the space provided, using the form's Help Text as a guide.

MEDICAL NECESSITY MET: Check the appropriate boxes, as indicated.

CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE: Provide the dates and check each item as completed.

Signatures: The clinician completing the form will sign his/her name with credential on the signature line, and print their name on the second line. Date and Anasazi Staff ID number are documented at the appropriate prompts.

When a clinician needs a co-signature, a qualified clinician will sign, print name, date and enter Anasazi Staff ID as indicated. Refer to Scope of Practice to identify who needs a co-signature.

San Diego County Mental Health Services
BEHAVIORAL HEALTH ASSESSMENT – ESU

***Client Name**: _____ ***Case #:** _____

***Assessment Date** _____ *** Program Name**: _____

***SOURCE OF INFORMATION**
(Select from Source of Information Table located in the Instructions sheet): _____
_____

If a source other than listed on the "Source of Information Table", specify: _____
_____

Interpreter Used: ☐ Offered ☐ Used ☐ Declined ☐ N/A

Reports Reviewed: _____
Agency Involvement: *Include names, relationships, and phone or contact information.*
_____

Referral Source: _____

***PRESENTING PROBLEMS/NEEDS** *Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and history of present illness. Summary of client's request for services including client's most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors; include experiences of stigma and prejudice, if any.*

_____
_____
_____
_____
_____
_____
_____

***PAST PSYCHIATRIC HISTORY** *Previous history of symptoms and/or mental health treatment. Describe in chronological order - where, when, and length of time. Include dates and providers related to any prior psychiatric treatment, history, traumatic and/or significant events, and/or trauma related to treatment. Include the most recent periods of stability and the characteristics of those periods.*

_____
_____
_____
_____
_____
_____
_____

MEDICAL HISTORY:

Does client have a Primary Care Physician? ☐ No ☐ Yes ☐ Unknown
If No, has client been advised to seek primary care? ☐ No ☐ Yes

Primary Care Physician: _____

Phone Number: _____

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

*Seen within the last: ☐ 6 months ☐ 12 months ☐ Other: _____

Hospital of choice (physical health): _____

Been seen for the following (provide dates of last exam):

Dental exam: _____

Hearing exam: _____

Vision exam: _____

*Physical Health issues: ☐ None at this time ☐ Yes

If Yes, specify: _____

_____

Is condition followed by Primary Care Physician? ☐No ☐Yes ☐N/A

Physical health problems affecting mental health functioning:

_____

_____

Head injuries: ☐No ☐Yes

If Yes, specify: _____

Medical and/or adaptive devices: _____

Significant Developmental Information (when applicable): _____

*Allergies and adverse medication reactions: ☐No ☐Unknown/Not Reported ☐Yes

If Yes, specify: _____

Medications (Active and Current Inactivations):

Med	Start Date	Is Date Estima-ted Y or N	Dosage/ Frequency	Amt. Prescribed	Target Sxs	Taken as Prescribed? Y, N or Unk	Prescribing Physician Name	**	Refills	Stop Date	Reason for Stopping

***Physician Type**: 1. current psychiatrist (out of network) 2. current PCP 3. previous psychiatrist (out of network) 4. previous PCP*

Other prescription medications: ☐None ☐Yes: _____

_____

Herbals/Dietary Supplements/Over the counter medications: ☐None ☐Yes:

_____

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

Healing and Health: *Alternative healing practices and beliefs. Apart from mental health professionals, who or what helps client deal with disability/illness and/or to address substance use issues? Describe*

_____

_____

Any known medical condition or past history of abuse that requires special consideration if physical restraint is needed, specifically: breathing problems, significantly overweight, pregnancy, etc? ☐ No ☐ Yes

If Yes, explain: _____

_____

VITAL SIGNS:

Height	Weight	Temp	Resp	Pulse	BP

Pain: ☐ No ☐ Yes ☐ Unable to determine

Pain Intensity Level: _____

Location of pain: _____ How long: _____

FAMILY HISTORY:

*Living Arrangement: *Select from Living Arrangement table listed in the Instructions Sheet*

_____

Those living in the home with client: _____

_____

Have any relatives ever had any of the following conditions (indicate who and expand below when applicable)

Select from Relatives table listed in the Instructions Sheet

.

Substance abuse or addiction: _____

Other addictions: _____

Suicidal thoughts, attempts: _____

Emotional/mental health issues: _____

Mental retardation: _____

Developmental delays: _____

Arrests: _____

Include relevant family information impacting the client: _____

_____

_____

_____

_____

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

EDUCATIONAL/EMPLOYMENT HISTORY:

Area(s) of Concern: ☐Academic ☐Employment

☐No issue reported ☐Other: _____

School Attending: *Refer to the Anasazi user manual for school table. If school is not on the table, select "other/private school" from the table.*

_____

Last grade completed: _____

Is Client AB2726? ☐ Yes ☐ No
Special Education Class: ☐ N/A
☐ Current:
☐ Past:
☐ Failed the following grade(s): _____

Client has an active IEP: ☐ No ☐ Yes

Socio-economic factors:
Occupation: _____
Last date worked: _____
Income source and level: _____
History of volunteer work: _____
Other important educational/vocational information: *Describe any involvement in any responsible employment, sought employment, employment successes, and educational successes.*

_____
_____

CULTURAL INFORMATION: *Specific cultural explanations for symptoms of behavior. Include immigration history and acculturation.*

_____
_____
_____
_____

SOCIAL HISTORY:

Peer/Social Support ☐ None reported ☐ Yes: _____

Sexuality: *May include lesbian, gay, bisexual, transgender, questioning.*
☐ None reported ☐ Yes: _____

Sexual concerns: ☐ None reported ☐ Yes: _____

Substance use by peers: ☐ None reported ☐ Yes: _____

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

Gang affiliations: ☐ None reported ☐ Yes: _____

Family/community support system: ☐ None reported ☐ Yes: _____

Religious/spiritual issues: ☐ None reported ☐ Yes: _____

Justice system involvement: ☐ None reported ☐ Yes: _____

Experience of stigma, prejudice, or barriers to accessing services:
☐None reported ☐Yes: _____

HISTORY OF VIOLENCE:

History of domestic violence: ☐ None reported ☐ Yes: _____
History of significant property destruction: ☐ None reported ☐ Yes: _____
History of violence: ☐ None reported ☐ Yes: _____
History of abuse: ☐ None reported ☐ Yes: _____
Abuse reported: ☐ N/A ☐ No ☐ Yes: _____

Experience of traumatic event/s: ☐No ☐Yes ☐Unknown/not reported
If Yes: _____
_____
_____

***SUBSTANCE USE INFORMATION**:

☐ Not applicable to client

CRAFFT (Administer measure by providing handout or reading questions verbatim, in order and without interpretation)

HAVE YOU EVER?		Yes	No
C-	Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?		
R-	Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?		
A-	Do you ever use alcohol/drugs while you are by yourself ALONE?		
F-	Do you ever FORGET things you did while using alcohol or drugs?		
F-	Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?		
T-	Have you ever gotten into TROUBLE while you were using alcohol or drugs?		

2 or more "Yes" answers suggests a significant problem. . **TOTAL:** _____

*Substance Use? ☐ No ☐ Yes ☐ Client Declined to Report

(if yes, specify substances used)

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

Name of Drug	Priority	Method of Admin-istration	Age 1st used	Freq-uency of Use	Days of use in last 30 days	Date of last use	Amount of last use	Amount used on a typical Day	Largest Amount Used in One Day

The client has been advised that smoking is a serious health risk that may lead to lung cancer, cardiovascular disease and the possibility of premature death.

☐Yes ☐N/A

When applicable, outline how substance use impacts current level of functioning:

_____
_____
_____
_____

History of substance use treatment:

_____
_____
_____

Recommendation for further substance use treatment: ☐ No ☐ Yes ☐Not applicable

If Yes:

_____
_____
_____

Quadrant: (CCISC – trained program/staff only)

☐ Q. I: Low / Low ☐ Q. II: High / Low
☐ Q III: Low / High ☐ Q. IV: High / High

Stages of Change: (CCISC – trained program/staff only)

☐ Pre-Contemplation ☐Contemplation
☐ Preparation/Determination ☐Action
☐ Maintenance

Gambling:

Have you ever felt the need to bet more and more money? ☐No ☐Yes

Have you ever had to lie to people important to you about how much you gambled? ☐No ☐Yes

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

MENTAL STATUS EXAM

☐ Unable to assess at this time.

Level of Consciousness

☐ Alert ☐ Lethargic ☐ Stuporous

Orientation

☐ Person ☐ Place ☐ Day ☐ Month ☐ Year ☐ Current Situation

☐ All Normal ☐ None

Appearance

☐ Good Hygiene ☐ Poor Hygiene ☐ Malodorous ☐ Disheveled

☐ Reddened Eyes ☐ Normal Weight ☐ Overweight ☐ Underweight

Speech

☐ Normal ☐ Slurred ☐ Loud ☐ Soft ☐ Pressured

☐ Slow ☐ Mute

Thought Process

☐ Coherent ☐ Tangential ☐ Circumstantial ☐ Incoherent ☐ Loose Association

Behavior

☐ Cooperative ☐ Evasive ☐ Uncooperative ☐ Threatening ☐ Agitated ☐ Combative

Affect

☐ Appropriate ☐ Restricted ☐ Blunted ☐ Flat ☐ Labile ☐ Other

Intellect

☐ Average ☐ Below Average ☐ Above Average ☐ Poor Vocabulary

☐ Poor Abstraction ☐ Paucity of Knowledge ☐ Unable to Rate

Mood

☐ Euthymic ☐ Elevated ☐ Euphoric ☐ Irritable ☐ Depressed ☐ Anxious

Memory

☐ Normal ☐ Poor Recent ☐ Poor Remote ☐ Inability to Concentrate

☐ Confabulation ☐ Amnesia

Motor

☐ Age Appropriate/Normal ☐ Slowed/Decreased ☐ Psychomotor Retardation

☐ Hyperactive ☐ Agitated ☐ Tremors ☐ Tics ☐ Repetitive Motions

Judgment

☐ Age Appropriate/Normal ☐ Poor ☐ Unrealistic

☐ Fair ☐ Limited ☐ Unable to Rate

Insight

☐ Age Appropriate/Normal ☐ Poor ☐ Fair ☐ Limited ☐ Adequate ☐ Marginal

Command Hallucinations

☐ No ☐ Yes, specify: _____

Auditory Hallucinations

☐ No ☐ Yes, specify: _____

Visual Hallucinations

☐ No ☐ Yes, specify: _____

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

Tactile Hallucinations

☐ No ☐ Yes, specify: _____

Olfactory Hallucinations

☐ No ☐ Yes, specify: _____

Delusions

☐ No ☐ Yes, specify: _____

Other observations/comments when applicable:

_____

_____

_____

_____

_____

_____

POTENTIAL FOR HARM/RISK ASSESSMENT

*Current Suicidal Ideation? ☐ No ☐Yes ☐Unknown/Refused

Specify plan (vague, passive, imminent):

_____

_____

Access to Means? ☐ No ☐Yes ☐Unknown/Refused

Describe:

_____

_____

Previous Attempts? ☐ No ☐Yes ☐Unknown/Refused

Describe:

_____

_____

Does the client agree not to hurt self or to seek help prior to acting on suicidal impulse?

☐ No ☐Yes ☐Unknown/Refused

Explain:

_____

_____

*Current Homicidal Ideation? ☐ No ☐Yes ☐Unknown/Refused

Specify plan (vague, intent, with/without means):

_____

_____

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

Identified Victim(s)? ☐ No ☐Yes Tarasoff Warning Indicated? ☐ No ☐Yes
Reported To: _____ Date: _____

Victim(s) name and contact information (Tarasoff Warning Details):

_____
_____
_____

Acts of Property Damage? ☐ Yes ☐ No Most Recent Date: _____

Gravely Disabled? ☐ Yes ☐ No
If yes, specify: _____

*Current Domestic Violence: ☐ No ☐Yes
Describe situation:

_____
_____
_____

Child/Adult Protective Services Notification Indicated? ☐ No ☐Yes
Reported to: _____ Date: _____

Specify Domestic Violence Plan (include Child/Adult Protective Services information):

_____
_____
_____

Urine Drug Screen: ☐ Positive ☐ Negative ☐ Pending ☐ Refused ☐ N/A

_____
_____

Breathalyzer: ☐ Positive ☐ Negative ☐ Pending ☐ Refused ☐ N/A

_____
_____

Comments Regarding Factors Increasing Risk: _____

_____
_____

Justice System Involvement? ☐ Yes ☐ No ☐Unknown
If yes, describe recent arrests, probation, sex offender information, et cetera:

_____
_____
_____

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

ASSESSMENT OF STRENGTHS

*I have considered the client's strengths: ☐ Yes ☐ No
If no, explain: _____

Check all that apply

Optimism/Hope	☐ Yes	☐ No	Hobbies/Special Interests	☐ Yes	☐ No
Sense of Meaning	☐ Yes	☐ No	Goal Directed/Motivated	☐ Yes	☐ No
Faith/Spirituality	☐ Yes	☐ No	Compassion/Altruism	☐ Yes	☐ No
Empathy/Caring	☐ Yes	☐ No	Stable Family Life	☐ Yes	☐ No
Resourcefulness	☐ Yes	☐ No	Communication	☐ Yes	☐ No
Self-Efficacy/Mastery	☐ Yes	☐ No	Internal Locus of Control	☐ Yes	☐ No
Academic History	☐ Yes	☐ No	Sense of Empowerment	☐ Yes	☐ No
Daily Living Skills	☐ Yes	☐ No	Work History	☐ Yes	☐ No
Self-Awareness	☐ Yes	☐ No	Living Environment	☐ Yes	☐ No
Flexibility	☐ Yes	☐ No	Positive Identity	☐ Yes	☐ No
Sense of Humor	☐ Yes	☐ No	Adaptive Distancing/Resistance	☐ Yes	☐ No
Responsiveness	☐ Yes	☐ No	Planning	☐ Yes	☐ No
Support System	☐ Yes	☐ No	Insight/Critical Thinking	☐ Yes	☐ No
Open to Change	☐ Yes	☐ No	Previous Positive Experience in Treatment	☐ Yes	☐ No
			Utilizes Agreed-Upon Treatment Recommendations	☐ Yes	☐ No

AREAS OF NEED

List of Problems: (Check all that apply)

Abuse/Addiction: Substance/Non-Substance	☐ Yes	☐ No
Basic Needs: Food, Clothing, Shelter	☐ Yes	☐ No
Education	☐ Yes	☐ No
Emotional-Behavioral/Psychiatric	☐ Yes	☐ No
Family Stress	☐ Yes	☐ No
Financial	☐ Yes	☐ No
Identity Issues: Cultural/Gender	☐ Yes	☐ No
Intimate Relationships	☐ Yes	☐ No
Lack of Physical Health Care	☐ Yes	☐ No
Legal	☐ Yes	☐ No
Meaningful Role (tied to self-determination)	☐ Yes	☐ No
Neglect/Abuse	☐ Yes	☐ No
Neurological/Brain Impairment	☐ Yes	☐ No
Physical Health Problems	☐ Yes	☐ No
Potential for Harm: Self/Others	☐ Yes	☐ No
Social Functioning	☐ Yes	☐ No
Spiritual	☐ Yes	☐ No
Stress	☐ Yes	☐ No
Trauma	☐ Yes	☐ No
Vocational/Employment	☐ Yes	☐ No

DIAGNOSIS If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Behavioral Health Assessment.

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

CLINICAL CONCLUSION: *Justification for diagnosis and medical necessity. Summarize and integrate all information gathered from other sources to render clinical judgments regarding intensity, length of treatment and recommendations for services. Clearly state those emotional or behavioral symptoms that interfere with normal functioning. Include evaluation of client's ability and willingness to solve the presenting problems, addressing both mental health and substance issues from an integrated perspective.*

_____
_____
_____
_____
_____
_____
_____
_____

Medical Necessity Met: ☐ No ☐ Yes

When "No," note date NOA-A issued [Medi-Cal clients only]: _____

CLIENT HAS BEEN INFORMED OF HIS/HER FREEDOM OF CHOICE? ☐Yes Date: _____

Local mental health program shall inform Clients receiving mental health services, including parents or guardians of children / adolescents, verbally or in writing that:

☐ Acceptance and participation in the mental health system is voluntary and shall not be considered a prerequisite for access to other community services;

☐ They retain the right to access other Medi-Cal or Short Doyle/Medi-Cal reimbursable services and have the right to request a change of provider, staff person, therapist, and/or case manager.

☐ **Guide to Medi-Cal Mental Health Services was explained and offered on: _____**

☐ **Grievance and Appeal Process explained and Brochure with form fill and envelope offered on: _____**

☐ **Provider List explained and offered on: _____**

☐ **Mental Health Plan's Notice of Privacy Practices (NPP) was offered on: _____**

☐ **Language/Interpretation services availability reviewed and offered when applicable on: _____**

☐ **Advanced Directive brochure was offered on: _____**

Signature of Clinician Requiring Co-signature:

_____ _____

Signature Date

_____ _____

Printed Name Anasazi ID number:

Client Name _____ Case Number _____

Assessment Date _____ Program Name _____

***Signature of Clinician Completing/Accepting the Assessment:**

_____ _____
Signature Date

_____ _____
Printed Name Anasazi ID number:

Signature of Staff Entering Information (if different from above):

_____ _____
Signature Date

_____ _____
Printed Name Anasazi ID number

INITIAL ASSESSMENT TBS - EHR

2012

WHEN: Within 30 calendar days of opening the client for TBS services. When significant changes occur the assessment may be revised by opening a new assessment, adding the updated information, and final approving the assessment. The Initial Assessment TBS does not meet the need for a Behavioral Health Assessment.

ON WHOM: All clients receiving TBS services.

COMPLETED BY: Staff delivering services within scope of practice. Must be signed by:

Physician,
Licensed/Waivered Psychologist,
Licensed/Registered/Waivered Social Worker,
Licensed/Registered/Waivered Marriage Family Therapist, or
Registered Nurse.
Trainee can complete but must be co-signed by one of the above.

Co-signatures must be completed for the Discharge Summary to be final approved.

MODE OF COMPLETION: Data must be entered into the Electronic Health Record.

REQUIRED ELEMENTS: All clinically appropriate elements should be completed.

NOTE: Every assessment within the EHR must be completed and final approved in a timely manner. When it is not completed and final approved (red locked), the system will prevent other servers from launching any assessments that contain shared fields. An assessment that is not final approved (status is “open green locked”) is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Assessments are not viewed as complete and active until the assessment is final approved (red locked).

San Diego County Mental Health Services
INITIAL TBS ASSESSMENT
(BEHAVIORAL HEALTH ASSESSMENT - TBS)
Instructions

CLIENT NAME: Required field

CASE NUMBER: Required field

ASSESSMENT DATE: Required field

PROGRAM NAME: Required field

SOURCE OF INFORMATION- Enter the name of the person providing information on the client.

ID	Description	ID	Description
AB2726 Asr	AB2726 Assessor	**Other**	Other
ADS Prov	ADS Recovery Provider	**Parent LG**	Parent/Legal Guardian
Case Mnager	Case Manager	**Parole**	Parole Officer
Client	Client	**Prev Asst**	Previous Assessment
Conservatr	Conservator	**Probation**	Probation Officer
Family	Family	**Soc Worker**	Social Worker
Fos Parent	Foster Parent	**Teacher**	Teacher/School
MD	MD	**Therapist**	Therapist

RELATIONSHIP: Enter the relationship to the client of the person providing assessment information.

TARGET BEHAVIORS: Using the table below, list the target behaviors in the space provided. If "other," then specify as indicated.

ID	Description
AWOL	AWOL
Hygiene	Hygiene
Poor Bound	Poor/Inappropriate Boundaries
Meds non	Meds non-compliance
Non comp	Non-compliant Behavior
Opp Def Be	Oppositional Defiant Behavior
Other	Other
Phys Aggr	Physical Aggression
Poor Soc	Poor Social Skills
Prop Dest	Property Destruction
Sch Truan	School Truancy/Tardiness
Self Harm	Self-Harm Behavior
Sex Behav	Sexualized Behavior
Suicidal	Suicidal Behavior
Verb Aggr	Verbal Aggression

DESCRIBE SPECIFIC BEHAVIORS: Use the space provided for narrative text.

IDENTIFICATION OF CURRENT SKILLS: Using the table below, list the client's current skills in the space provided. If "other," then specify as indicated.

ID	Description
Feelings	Expresses feelings asso.w prob bx
Predict	Predict problematic bx or situations
Soothe	Able to soothe self
Time Out	Able to take timeouts
Accepts	Accepts consequences

Truthful	Is usually truthful
Other	Other
Remorse	Shows remorse
Respnsibl	Takes responsibility for behavior
Understand	Shows remorse

WHAT INTERVENTIONS/CONSEQUENCES HAVE BEEN EFFECTIVE: Use the space provided for narrative text.

MEDICATIONS: List medications, dosages and other pertinent information in the spaces provided.

OTHER RESOURCES TRIED OR CONSIDERED: Using the table below, list the other resources tried or considered in the space provided. If "other," then specify as indicated. Document the results of these services where indicated.

ID	Description
Day Tx	Day Treatment
Fam Tx	Family Therapy
Group TX	Group Therapy
Hospital	Hospitalization
Indiv Tx	Individual Therapy
Meds Tx	Medication Therapy
Probation	Probation
Other	Other
Reg Cntr	Regional Center
Resl Tx	Residential Treatment
SES	SES
TBS	TBS
Wraparound	Wrap-around

DESIRED OUTCOME/RESULT OF TBS SERVICES: Choose the appropriate response by marking one of the check boxes listed.

DAYS AND TIMES TBS MAY BE REQUESTED, BASED ON PROBLEMATIC BEHAVIORS: Indicate request by check box and documentation in spaces provided.

SIGNATURES: The clinician completing the form will sign his/her name with credential on the signature line, and print their name on the second line. Date and Anasazi Staff ID number are documented at the appropriate prompts.

San Diego County Mental Health Services
INITIAL TBS ASSESSMENT

*Client Name:_____ *Case #:_____

*Assessment Date: _____ *Program Name:_____

SOURCE OF INFORMATION (Select from Source of Information Table located in the Instructions sheet):
_____
_____

RELATIONSHIP (Choose from Family Member List located in the instruction's sheet):
_____

Target Behaviors: (Identify child/youth's specific behaviors/symptoms that jeopardize continued placement in a current facility or are expected to interfere when the child/youth is transitioning to a lower level of residential placement): *see table located in the instruction sheet:*
_____
_____
_____
_____

If Other, specify: _____
_____
_____

Describe Specific Behaviors (Identify Current frequency, severity, and duration of specific behaviors associated with Target Behaviors. Also identify the desired frequency, severity, and duration):
_____
_____
_____
_____
_____

Identification of Current Skills (Choose from the TBS Skills Current table located in the instruction's sheet):
_____
_____
_____

If Other, specify:
_____
_____
_____

What interventions/consequences have been effective?
_____
_____
_____
_____

Client Name:_____ **Case #:_____**

Assessment Date: _____ ***Program Name:_____**

_____

Medications (Active and Current Inactivations)

Med	Start Date	Is Date Estimated Y or N	Dosage/ Frequency	Amt. Prescribed	Target Sxs	Taken as Pres-cribed? Y, N or Unk	Pre-scribing Physi-cian Name	Phys-ician Type *(see below for code)	Refills	Stop Date	Reason for Stopping

**Physician Type: 1. current psychiatrist (out of network) 2. current PCP 3. previous psychiatrist (out of network) 4. previous PCP*

Other Services or Resources Tried or Considered (Choose from the TBS Services table located in the instruction's sheet):

_____

_____

_____

If Other, specify:

_____

_____

_____

What were the results of these services? (Discuss duration and outcomes of previous treatment and how TBS is justified):

_____

_____

_____

Desired outcome/result of TBS services:

☐Prevent Higher Level of Care

☐Transition to Lower of Care

☐Prevent Psychiatric Hospitalization

Days and Times TBS may be requested, based on problematic behaviors:

☐Monday: _____
☐Tuesday: _____
☐Wednesday: _____
☐Thursday: _____
☐Friday: _____
☐Saturday: _____
☐Sunday: _____

Signature of Clinician Completing/Accepting the Assessment:

_____ _____

Signature Date

_____ _____

Printed Name Anasazi ID number

Signature of Staff Entering Information (if different from above):

_____ _____

Signature Date

_____ _____

Printed Name Anasazi ID number

HIGH RISK ASSESSMENT (HRA) INSTRUCTIONS

2013

PURPOSE: Suicide and violent assault are very serious public health concerns nationwide and in San Diego County. The HRA and the HRP (High Risk Plan) are designed to identify, assess and create a safety plan for high risk clients.

WHEN: Completion of the HRA is recommended as part of the initial assessment process, and thereafter anytime a client presents with risk factors.

ON WHOM: Any client receiving mental health services within BHS System of Care.

COMPLETED BY: Any direct service provider delivering services within their scope of practice. A Co-signature is required for all non-licensed, registered or waivered staff, LVN's and LPT's.

MODE OF COMPLETION: Legibly handwritten or typed.

REQUIRED ELEMENTS: All elements must be assessed.

NOTE: In the future (projected to be approximately 7/1/13) the HRA will be incorporated into BHAs, and the HRP will be a separate electronic form in Anasazi. Once this occurs, the HRA will required to be completed on all clients. The HRP will be required if specific criteria are met on the HRA.

The paper HRA and the HRP should be kept in the paper client chart.

HIGH RISK ASSESSMENT (HRA)

CLIENT NAME: CASE NUMBER:

HIGHEST RISK INDICATORS: ANY YES RESPONSE WILL REQUIRE COMPLETION OF A HIGH RISK PLAN

Current Suicidal Ideation with intent	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Currently fearful of hurting self or others and cannot reassure that he/she would seek help first	☐ No	☐ Yes	☐ Refuse/Cannot Assess
History of or recent potentially lethal self destructive, arson, or assault attempt?	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Suicide of 1st degree relative?	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Pre-death behavior/committed to dying (settling obligations, give away possessions)	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Incapacitating illness	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Chronic intractable pain	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Command hallucinations to significantly harm self or others	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Preoccupation with diagnosis of life threatening illness	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Current caretaker has a "highest risk" indicator	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Extreme isolation (Child to 25 yrs of age)	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Victim of bullying (Child to 25 yrs of age)	☐ No	☐ Yes	☐ Refuse/Cannot Assess

A **YES or Refuse/Cannot Assess** response to any of the above HIGHEST RISK INDICATORS requires detailed documentation:

Current Homicidal Ideation? ☐ No ☐ Yes ☐ Refuse/Cannot Assess

A **YES or Refuse/Cannot Assess** response requires detailed documentation and mandatory victim question.
Specify plan (vague, intent, with/without means):

Reasonably identifiable victim(s)? ☐ No ☐ Yes Tarasoff Warning Indicated? ☐ No ☐ Yes

Reported To: Date:

If yes, detailed documentation mandatory. Include victim(s) name and contact information (Tarasoff Warning Details):

Current Domestic Violence? ☐ No ☐ Yes ☐ Refuse/Cannot Assess

If yes, detailed documentation and child/adult protective services question mandatory. Describe situation:

Child/Adult Protective Services Notification Indicated? ☐ No ☐ Yes

Reported To: Date:

Specify Domestic Violence Plan (include Child/Adult Protective Services Information):

A **YES** response to any of the above **HIGHEST RISK INDICATORS** requires a **HIGH RISK PLAN**.

For all unlicensed staff, documentation of a consultation is required in the High Risk Plan. For trainees specifically, review with supervisor is required prior to end of session.

OTHER RISK INDICATORS

Age, gender, race, sexual orientation (Demographic factors)	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Sexual or gender identity issues	☐ No	☐ Yes	☐ Refuse/Cannot Assess
History of fantasy or plan to harm self/others	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Witness of suicide	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Military/veteran	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Recent (under 1 year) return from combat zone	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Stressful caretaking role	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Law enforcement (past or present employment)	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Discharge from 24 hour program (hospital, IMD, START, residential treatment, etc) – (Recent, within 3 months)	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Release from criminal custody – (Recent, within 3 months)	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Alcohol/drug residential treatment failure – (Recent, within 3 months)	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Anniversary of important loss	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Health deterioration of self or significant others – (Recent)	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Victimization –commercial sex exploitation, sexual abuse, incest, physical abuse, domestic violence, bullying, or other assault – (Recent, within approx. 3 mos.)	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Unresolved significant loss (people, pets, jobs, shelter) – (Recent, within approx. 3 mos.)	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Unresolved legal or financial problems - (Recent, within approx. 3 mos.)	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Gravely disabled – (Recent, within approx.3 mos.)	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Extreme social isolation, real or perceived	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Immigration/refugee issues	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Justice system involvement, past or present	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Gang exposure	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Homelessness or imminent risk thereof	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Access to means to harm self/others	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Previous attempts to harm self/others	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Easy access to firearms or firearms in home	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Experience in handling firearms	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Anti-social behavior – (Recent, within approx. 3 mos.)	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Acts of property damage – (Recent, within approx. 3 mos.)	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Risk taking or self-destructive acts	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Documented borderline, anti-social, or personality disorder	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Documented eating disorder	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Sleeplessness	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Psychomotor agitation	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Panic attacks	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Difficulty making decisions	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Guilt or worthlessness	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Rage	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Impulse control problem	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Substance abuse relapse – (Recent, within 3 months)	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Co-occurring mental and substance abuse disorder	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Current abuse or misuse of drugs and other substances	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Significant change in mood – (Recent, within approx. 3 mos.)	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Hopelessness/sees no options	☐ No	☐ Yes	☐ Refuse/Cannot Assess

A **YES or Refuse/Cannot Assess** response to any of the above OTHER RISK INDICATORS requires detailed documentation.

PROTECTIVE FACTORS

Strong religious or cultural values or prohibition	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Strong social support system	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Positive planning for future	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Engages in treatment	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Valued care giving role (people or pets)	☐ No	☐ Yes	☐ Refuse/Cannot Assess
Strong attachment/responsibility to others			

A **YES or Refuse/Cannot Assess** response to any of the above PROTECTIVE FACTORS requires detailed documentation.

Signature of Clinician Requiring Co-Signature:_____ Date:

Signature of Clinician Completing/Accepting Assessment:_____ Date:

HIGH RISK PLAN (HRP)

CLIENT NAME: CASE NUMBER:

Completion or update of High Risk Assessment (HRA) should be noted in Progress Note on same date.

After evaluation of all risks in light of relevant mitigating factors, note whatever appropriate actions are taken, below.

☐ **ACTIVE HRP** Effective Date:

Consultation: ***If immediate risk, trainee consultation to occur before client leaves program/office.***

☐ In-house clinical or administrative supervisor
☐ Treatment team members
☐ Colleague

Date of consultation: With whom:
Outcome:

☐ Communicate risk to other programs or staff who may assume responsibility (covering staff, EPU, ESU, PERT, hospital, CPS, APS, etc.)
Describe:

☐ Consideration of higher level of care or service (case management, FSP, organizational provider, hospital, more frequent sessions, phone calls, etc.)
Describe:

☐ Contact client's family member, caretaker or designated emergency contact. (Should cross reference to Progress Note for details)
Who: Date:

☐ Linkage to additional resources:

☐ Current treatment plan was revised? ☐ No ☐ Yes
If no, rationale:

☐ Use of Protective Factors
Describe:

☐ **INACTIVE HRP** Effective Date:
Describe:

Signature of Clinician Requiring Co-Signature: _____ Date:

Signature of Clinician Completing/Accepting Assessment: _____Date:

MENTAL HEALTH SERVICES

2012

UM/OUTCOME EVALUATIONS/ MEASURES

NOTE: Outcome evaluation/measure tools are obtained by contacting CASRC via email at soce@casrc.org or via phone at 858-966-7703 ext 3508. Questions regarding data collection and data entry into the DES/SOCE should also be directed to CASRC for the Children's programs. For the Adult programs outcome evaluation/measures are obtained by contacting HASRC.

MENTAL HEALTH SERVICES

2012

CHILDREN'S PROGRAMS

YOUTH TRANSITION SELF-EVALUATION - PAPER

2012

WHEN: For clients 16 years or older, within 30 calendar days of opening the client's assignment according to age (see "On Whom"). When client has been in the System of Care, the evaluation form should be requested from the prior provider. If the evaluation is not received prior to the thirty days, a new evaluation shall be completed.

ON WHOM: All clients age 16 years or older, including those already in the Children's Mental Health System of Care. The evaluation form must be updated at age 17, 17 1/2, 18 and yearly thereafter until client is discharged from Children's Mental Health System of Care.

COMPLETED BY: Client shall complete the evaluation, and when needed staff may assist the client in completing the form.

MODE OF COMPLETION: Youth Transition Self-Evaluation form (MHS-624) and filed in the hybrid chart.

REQUIRED ELEMENTS: Complete all prompts. The following five life domains are rated by circling a 1 to 5 or non applicable scale:

- Health / Mental Health,
- Social Skills,
- Daily Living Skills,
- Financial, and
- Educational /Vocational.

Staff must address any item/s that result in a score of less than 3 by a written comment in the "Action" section of the form**.**

NOTE: The Youth Transition Self-Evaluation form may be imported from previous assignments or other providers.

Date Completed: _____

Please read each of the following LIFE DOMAIN statements and circle the answer that sounds the most like you:

HEALTH/MENTAL HEALTH	No, Not at All		Somewhat		Yes, Definitely	N/A
1. I know how to keep my mental health services, or get them going again.	1	2	3	4	5	N/A
2. I know how to get a copy of my file if I need one.	1	2	3	4	5	N/A
3. I know what problems I have and how to get the help I need.	1	2	3	4	5	N/A
4. I know how to find a therapist or doctor and how to make an appointment.	1	2	3	4	5	N/A
5. I know the names of the medicines I take.	1	2	3	4	5	N/A
6. I know and can say why I take the medicines.	1	2	3	4	5	N/A
7. I know how to get more of my medicine so I don't run out.	1	2	3	4	5	N/A
8. I know how to get help if I have a problem with drugs or alcohol.	1	2	3	4	5	N/A
9. I know what taking illegal drugs, alcohol or smoking can do to my body.	1	2	3	4	5	N/A
10. I can explain the side effects my medicines can cause.	1	2	3	4	5	N/A
11. I show appropriate self-control.	1	2	3	4	5	N/A
12. I know some things I can do to deal with stress.	1	2	3	4	5	N/A
13. I know how I can prevent pregnancy & sexually transmitted diseases.	1	2	3	4	5	N/A

ACTIONS/COMMENTS:_____

_____

SOCIAL SKILLS	No, Not at All		Somewhat		Yes, Definitely	N/A
1. During my free time, I find something to do that doesn't get me into trouble.	1	2	3	4	5	N/A
2. I have positive free time activities that I enjoy.	1	2	3	4	5	N/A
3. I am involved in group activity (sports, youth group, etc.).	1	2	3	4	5	N/A
4. I can explain how I am feeling.	1	2	3	4	5	N/A
5. I can handle things that make me mad without yelling, hitting, or breaking things.	1	2	3	4	5	N/A
6. I talk over problems with friends/family.	1	2	3	4	5	N/A
7. I am willing to have my family or friends help me.	1	2	3	4	5	N/A
8. I have friends my own age.	1	2	3	4	5	N/A
9. I know how to be polite to others.	1	2	3	4	5	N/A
10. I am able to introduce myself to new people.	1	2	3	4	5	N/A
11. I know how to be a good listener, and ask questions when I need to understand better.	1	2	3	4	5	N/A
12. I know some ways I could help others who live near me.	1	2	3	4	5	N/A
13. I can explain my own cultural background.	1	2	3	4	5	N/A

ACTIONS/COMMENTS:_____

_____

Client:_____

InSyst #:_____

Program:_____

DAILY LIVING SKILLS	No, Not at All		Somewhat		Yes, Definitely	N/A
1. I know who to call if there is an emergency.	1	2	3	4	5	N/A
2. I keep my teeth and body clean.	1	2	3	4	5	N/A
3. I know how to do my own laundry.	1	2	3	4	5	N/A
4. I keep my room clean.	1	2	3	4	5	N/A
5. I know how to buy things at the grocery store.	1	2	3	4	5	N/A
6. I know how to cook my own meals.	1	2	3	4	5	N/A
7. I know what foods I should eat to keep me healthy.	1	2	3	4	5	N/A
8. I know how to get a driver's license or California I.D.	1	2	3	4	5	N/A
9. I know how to use buses or other public transportation.	1	2	3	4	5	N/A
10. I can give somebody directions to where I live.	1	2	3	4	5	N/A
11. I can take care of myself if I am sick or get hurt, and I know where to get help.	1	2	3	4	5	N/A
12. I know how to get something fixed at home if it is broken.	1	2	3	4	5	N/A
13. I know what could be unsafe in my home and how to fix it.	1	2	3	4	5	N/A
14. I know how to find a place to live.	1	2	3	4	5	N/A

ACTIONS/COMMENTS:_____

_____

FINANCIAL	No, Not at All		Somewhat		Yes, Definitely	N/A
1. I know how to manage my money so I can always pay my bills.	1	2	3	4	5	N/A
2. I know how to write a check, use a credit card or a debit card, and I know how to pay by cash and get the right change back.	1	2	3	4	5	N/A
3. I know how to decide what to buy first if I want several things and don't have enough money for everything.	1	2	3	4	5	N/A
4. I can explain the good & bad points of buying on credit.	1	2	3	4	5	N/A

ACTIONS/COMMENTS:_____

_____

EDUCATIONAL/VOCATIONAL	No, Not at All		Somewhat		Yes, Definitely	N/A
1. I know what helps me learn new things.	1	2	3	4	5	N/A
2. I know what I like to do.	1	2	3	4	5	N/A
3. I know what I am good at doing.	1	2	3	4	5	N/A
4. I know what my educational goals are.	1	2	3	4	5	N/A
5. I know how to meet my educational goals.	1	2	3	4	5	N/A
6. I know what kind of job or career I would like to have.	1	2	3	4	5	N/A
7. I can explain the education and/or training needed for my career options.	1	2	3	4	5	N/A
8. I can find out what kinds of activities/classes an organization offers.	1	2	3	4	5	N/A
9. I know coming to work on time every day is very important, and I can do it.	1	2	3	4	5	N/A
10. I get my work done on time.	1	2	3	4	5	N/A
11. I follow directions from my supervisor/teacher.	1	2	3	4	5	N/A

ACTIONS/COMMENTS:_____

_____

STAFF TO SEE INSTRUCTIONS REGARDING ITEMS THAT MUST BE ADDRESSED.

County of San Diego - CMHS

Client:_____

InSyst #:_____

YOUTH TRANSITION SELF-EVALUATION

Program:_____

Fecha en que se completó: _____

Por favor lea cada una de las siguientes afirmaciones sobre los diferentes ASPECTOS DE LA VIDA y marque con un círculo la respuesta que le parezca más cercana a lo que usted sabe o hace:

SALUD FÍSICA / MENTAL	No, no sé		Sé un poco		Sí, sí sé	N/A
1. Sé cómo conservar mis servicios de salud mental o cómo reactivarlos.	1	2	3	4	5	N/A
2. Sé cómo obtener una copia de mi expediente si lo necesito.	1	2	3	4	5	N/A
3. Sé los problemas que tengo y cómo conseguir la ayuda que necesito.	1	2	3	4	5	N/A
4. Sé cómo buscar a un terapeuta o a un médico y sé como hacer una cita con él o con ella.	1	2	3	4	5	N/A
5. Sé los nombres de los medicamentos que tomo.	1	2	3	4	5	N/A
6. Sé y puedo decir porqué tomo los medicamentos.	1	2	3	4	5	N/A
7. Sé cómo volver a surtir mis medicamentos para que no me falten.	1	2	3	4	5	N/A
8. Sé cómo obtener ayuda si tengo problemas de alcohol o de drogas.	1	2	3	4	5	N/A
9. Sé lo que le puede pasarle a mi cuerpo si fumo, consumo alcohol y/o drogas controladas.	1	2	3	4	5	N/A
10. Puedo explicar los efectos secundarios de los medicamentos que tomo.	1	2	3	4	5	N/A
11. Demuestro tener el autocontrol adecuado.	1	2	3	4	5	N/A
12. Sé de algunas cosas que puedo hacer para manejar el estrés /la tensión.	1	2	3	4	5	N/A
13. Sé cómo puedo prevenir el embarazo y las enfermedades de transmisión sexual.	1	2	3	4	5	N/A

ACCIONES/COMENTARIOS:_____
_____

CAPACIDAD PARA INTERACTUAR CON LOS DEMÁS	No, no sé		Sé un poco		Sí, sí sé	N/A
1. En mi tiempo libre busco hacer cosas que no me metan en problemas.	1	2	3	4	5	N/A
2. En mi tiempo libre realizo actividades positivas que disfruto.	1	2	3	4	5	N/A
3. Formo parte de actividades en grupo (deportes, grupos juveniles, etc.)	1	2	3	4	5	N/A
4. Puedo explicar cómo me siento.	1	2	3	4	5	N/A
5. Puedo manejar situaciones que me enojan, sin necesidad de gritar, pegar o romper cosas.	1	2	3	4	5	N/A
6. Hablo de los problemas con mi familia y mis amigos.	1	2	3	4	5	N/A
7. Estoy dispuesto(a) a que mi familia o mis amigos me ayuden.	1	2	3	4	5	N/A
8. Tengo amigos de mi misma edad.	1	2	3	4	5	N/A
9. Sé comportarme educadamente con los demás.	1	2	3	4	5	N/A
10. Soy capaz de presentarme yo solo a personas que no conozco.	1	2	3	4	5	N/A
11. Sé cómo escuchar y sé hacer preguntas cuando quiero entender mejor algo.	1	2	3	4	5	N/A
12. Sé cómo ayudar a las otras personas que viven cerca de mí.	1	2	3	4	5	N/A
13. Puedo explicar mi formación cultural.	1	2	3	4	5	N/A

ACCIONES/COMENTARIOS:_____
_____
___

Client:_____

InSyst #:_____

Program:_____

CAPACIDAD PARA SOBREVIVIR	No, no sé		Sé un poco		Sí, sí sé	N/A
1. Sé a quién llamar en caso de una emergencia.	1	2	3	4	5	N/A
2. Mantengo mi cuerpo y mis dientes limpios.	1	2	3	4	5	N/A
3. Sé cómo lavar mi ropa.	1	2	3	4	5	N/A
4. Mantengo limpio mi cuarto.	1	2	3	4	5	N/A
5. Sé cómo comprar cosas en la tienda de comestibles.	1	2	3	4	5	N/A
6. Sé cómo preparar mis comidas.	1	2	3	4	5	N/A
7. Sé los alimentos que debo consumir para mantenerme sano(a).	1	2	3	4	5	N/A
8. Sé cómo sacar una licencia para conducir o una credencial de identificación de California.	1	2	3	4	5	N/A
9. Sé cómo transportarme en autobuses y en otro tipo de transporte público.	1	2	3	4	5	N/A
10. Puedo dar instrucciones sobre cómo llegar al lugar en donde vivo.	1	2	3	4	5	N/A
11. Puedo cuidarme a mi mismo(a) si estoy enfermo(a), y sé dónde conseguir ayuda.	1	2	3	4	5	N/A
12. Sé cómo componer algo en casa si está descompuesto.	1	2	3	4	5	N/A
13. Sé lo que puede ser peligroso en la casa y cómo eliminar el peligro.	1	2	3	4	5	N/A
14. Sé cómo buscar vivienda.	1	2	3	4	5	N/A

ACCIONES/COMENTARIOS:_____

FINANZAS	No, no sé		Sé un poco		Sí, sí sé	N/A
1. Sé cómo manejar mi dinero para poder pagar siempre mis cuentas.	1	2	3	4	5	N/A
2. Sé cómo escribir un cheque, usar tarjeta de crédito o de débito, y sé cómo pagar en efectivo y recibir el cambio correcto.	1	2	3	4	5	N/A
3. Sé decidir que debo comprar primero cuando hay varias cosas que deseo y no suficiente dinero para todas.	1	2	3	4	5	N/A
4. Puedo explicar lo bueno y lo malo de comprar a crédito.	1	2	3	4	5	N/A

ACCIONES/COMENTARIOS:_____

EDUCACIÓN / PROFESIÓN	No, no sé		Sé un poco		Sí, sí sé	N/A
1. Sé qué es lo que me ayuda a aprender cosas nuevas.	1	2	3	4	5	N/A
2. Sé lo que me gusta hacer.	1	2	3	4	5	N/A
3. Sé para lo que soy bueno.	1	2	3	4	5	N/A
4. Sé cuáles son mis metas de educación.	1	2	3	4	5	N/A
5. Sé cómo alcanzar mis metas de educación.	1	2	3	4	5	N/A
6. Sé el tipo de trabajo o de carrera que deseo tener.	1	2	3	4	5	N/A
7. Puedo explicar la educación y/o el entrenamiento que se necesita para las carreras que deseo seguir.	1	2	3	4	5	N/A
8. Puedo averiguar que tipo de actividades o de clases ofrece una organización.	1	2	3	4	5	N/A
9. Sé que llegar a tiempo al trabajo es muy importante, y yo puedo hacerlo.	1	2	3	4	5	N/A
10. Termino mi trabajo a tiempo.	1	2	3	4	5	N/A
11. Sigo las instrucciones de mi supervisor / profesor.	1	2	3	4	5	N/A

ACCIONES/COMENTARIOS:_____

STAFF TO SEE THE INSTRUCTIONS REGARDING ITEMS THAT MUST BE ADDRESSED

County of San Diego - CMHS

Client:_____

InSyst #:_____

YOUTH TRANSITION SELF-EVALUATION

Program:_____

Ngaøy ñieàn xong : _____

Xin caùc baïn vui loøng ñoïc caùc khung döôùi ñaây vaø khoanh troøn caâu naøo dieãn taû ñuùng nhaát con ngöôøi cuûa baïn

SÖÙC KHOEÛ/SÖÙC KHOEÛ TAÂM THAÀN	Khoâng , Khoâng chuùt naøo				Vaâng, Phaàn naøo	
Chaéc chaén						N/A
1. Toâi bieát giöõ nhöõng dòch vuï taâm thaàn, hoaëc tieáp tuïc trôû laïi nhaän nhöõng dòch vuï naøy.	1	2	3	4	5	N/A
2 Toâi bieát caùchlaáy baûn sao cuûa hoà sô toâi neáu toâi caàn.	1	2	3	4	5	N/A
3. Toâi bieát toâi bò ñau gì vaø tìm ñöôïc söï giuùp ñöõ khi caàn.	1	2	3	4	5	N/A
4. Toâi bieát tìm chuyeân vieân trò lieäu hoaëc baùc só vaø bieát saép xeáp buoåi heïn.	1	2	3	4	5	N/A
5. Toâi bieát teân nhöõng thöù thuoác toâi uoáng.	1	2	3	4	5	N/A
6. Toâi bieát vaø toâi coù theå noùi taïi sao toâi uoáng thuoác.	1	2	3	4	5	N/A
7. Toâi bieát caùch coù theâm thuoác uoáng ñeå khoûi bò heát thuoác.	1	2	3	4	5	N/A
8. Toâi bieát tìm söï giuùp ñöõ neáu toâi nghieän caàn sa hay nghieän röôïu.	1	2	3	4	5	N/A
9. Toâi bieát vieäc gì seõ xaûy ra cho theå xaùc toâi khi toâi duøng nhöõng loaïi ma tuùy baát hôïp phaùp, khi uoáng röôïu hoaëc huùt thuoác laù.	1	2	3	4	5	N/A
10. Toâi coù theå giaûi thích phaûn öùng phuï do thuoác toâi uoáng.	1	2	3	4	5	N/A
11. Toâi coù thaùi ñoä töï chuû ñuùng luùc.	1	2	3	4	5	N/A
12. Toâi bieát moät soá ñieàu toâi coù theå laøm ñeå giaûi quyeát söï caêng thaúng.	1	2	3	4	5	N/A
13. Toâi bieát caùch ngaên ngöøa thuï thai vaø caùc beäänh truyeàn nhieãm tình duïc.	1	2	3	4	5	N/A

BIEÄN PHAÙP/NHAÄN XEÙT: _____

_____

_____

KYÕ NAÊNG GIAO TEÁ	Khoâng, Khoâng chuùt naøo			Phaàn naøo		Chaéc
Vaâng chaén						N/A
1. Trong luùc roãi raõnh, toâi tìm vieäc ñeå laøm ñeå khoûi sa vaøo nhöõng baát traéc.	1	2	3	4	5	N/A
2. Toâi coù thì giôø raõng rang ñeå tham gia nhöõng sinh hoaït maø toâi thích.	1	2	3	4	5	N/A
3. Toâi coù tham gia sinh hoaït nhoùm (theå thao, nhoùm treû, vaân vaân...).	1	2	3	4	5	N/A
4. Toâi coù theå giaûi thích caûm nhaän cuûa toâi.	1	2	3	4	5	N/A
5. Toâi coù theå giaûi quyeát nhöõng vieäc khieán toâi töùc giaän maø khoâng phaûi la heùt, ñaùnh ñaám, hay ñaäp beå ñoà ñaïc.	1	2	3	4	5	N/A
6. Toâi thaûo luaän nhöõng vaán ñeà khoâng oån vôùi baïn be/ø gia ñình toâi.	1	2	3	4	5	N/A
7. Toâi saün saøng ñeå gia ñình vaø baïn beø giuùp toâi.	1	2	3	4	5	N/A
8. Toâi coù nhöõng ngöôøi baïn cuøng tuoåi.	1	2	3	4	5	N/A
9. Toâi bieát cö xöû leã ñoä vôùi moïi ngöôøi.	1	2	3	4	5	N/A
10. Toâi coù theå giôùi thieäu chính toâi vôùi nhöõng ngöôøi	1	2	3	4	5	N/A

môùi quen.						
11. Toâi bieát laøm moät ngöôøi chaêm chuù nghe, vaø ñaët caâu hoûi khi toâi muoán hieåu roõ hôn.	1	2	3	4	5	N/A
12. Toâi bieát moät vaøi caùch ñeå giuùp nhöõng ngöôøi khaùc soáng gaàn toâi.	1	2	3	4	5	N/A
13. Toâi coù theå giaÛi thích khaÛ naÊng vaÊn hoùa cuÛa toõi.	1	2	3	4	5	N/A

BIEÄN PHAÙP/NHAÄN XEÙT: _____

KYÕ NAÊNG SOÁNG MOÂÓ NGAØY **Chaéc chaén N/A**	**Khoâng,**	**Khoâng chuùt naøo**			**Vaâng**	**Phaàn naø**
1. Toâi bieát goïi ai khi coù vieäc caáp cöùu.	1	2	3	4	5	N/A
2. Toâi giöõ saïch seõ raêng vaø thaân theå toâi.	1	2	3	4	5	N/A
3. Toâi bieát caùch tö giaët quaàn aùo.	1	2	3	4	5	N/A
4. Toâi giöõ phoøng toâi saïch seõ.	1	2	3	4	5	N/A
5. Toâi bieát mua saém ôû tieäm taïp hoùa.	1	2	3	4	5	N/A
6. Toâi bieát töï naáu caùc böõa aên cuûa toâi.	1	2	3	4	5	N/A
7. Toâi bieát phaûi aên thöùc aên naøo ñeå ñöôïc khoeû maïnh.	1	2	3	4	5	N/A
8. Toâi bieát caùch laáy baèng laùi xe hay theû chöùng minh caù nhaân Cali.	1	2	3	4	5	N/A
9. Toâi bieát duøng xe buyùt hay phöông tieän giao thoâng coâng coäng khaùc.	1	2	3	4	5	N/A
10. Toâi coù theå chæ ñöôøng cho ngöôøi ta ñeán nôi toâi cö nguï.	1	2	3	4	5	N/A
11. Toâi co ùtheå tö chaêm soùc khi toâi beänh hay bò thöông, vaø toâi bieát ñeán ñaâu ñeå tìm sö giuùp ñöõ.	1	2	3	4	5	N/A
12. Toâi coù theå söõa chöõa nhöõng thöù ôû nhaø khi noù bò hö, gaûy beå.	1	2	3	4	5	N/A
13. Toâi bieát nhöõng ñieàu khoâng an toaøn ôû nhaø vaø bieát caùch söõa chöaõ.	1	2	3	4	5	N/A
14. Toâi coù theå tìm moät nôi ñeå cö nguï.	1	2	3	4	5	N/A

BIEÄN PHAÙP/NHAÄN XEÙT: _____

TAØI CHAÙNH **Chaéc chaén N/A**	**Khoâng**	**Khoâng chuùt naøo**			**Vaâng ,**	**Phaàn naøo**
1. Toâi bieát caùch söû duïng tieàn baïc neân toâi coù theå traû tieàn caùc hoùa ñôn.	1	2	3	4	5	N/A
2. Toâi bieát caùch vieát 1 caùi check, duøng theû tín duïng hay theû tieàn maët, vaø toâi bieát caùch traû baèng tieàn maët vaø laáy ñuùng soá tieàn thoái laïi.	1	2	3	4	5	N/A
3. Toâi bieát quyeát ñònh mua caùi gi tröôùc trong soá nhuõng thöù toâi caàn vaø toâi bieát toâi khoâng ñuû tieàn ñeå mua taát caû.	1	2	3	4	5	N/A
4. Toâi coù theå giaûi thích ñieàu lôïi vaø baát lôi khi mua chòu.	1	2	3	4	5	N/A

BIEÄN PHAÙP/NHAÄN XEÙT: _____

HOÏC VAÁN/ NGHEÀ NGHIEÄP naøo Chaéc chaén N/A	Khoâng		Khoâng chuùt naøo		Vaâng, Phaàn	
1. Toâi bieát nhöõng gì giuùp toâi hoïc hoûi ñieàu môùi.	1	2	3	4	5	N/A
2. Toâi bieát toâi thích laøm gì.	1	2	3	4	5	N/A
3. Toâi bieát toâi gioûi laøm vieäc gì.	1	2	3	4	5	N/A
4. Toâi bieát muïc ñích cuûa vieäc hoïc vaán.	1	2	3	4	5	N/A
5. Toâi bieát caùch ñaït ñöôïc muïc ñích hoïc vaán cuûa toâi.	1	2	3	4	5	N/A
6. Toâi bieát toâi thích ngheà gì, vieäc gì maø toâi muoán laøm.	1	2	3	4	5	N/A
7. Toâi coù theå giaûi thích hoïc vaán vaø huaán luyeän caàn phaûi coù ñeå cho toâi choïn löa ngheà nghieäp.	1	2	3	4	5	N/A
8. Toâi coù theå tìm ra caùc lôùp vaø sinh hoaït maø caùc hoâi ñoaøn cung caáp.	1	2	3	4	5	N/A
9. Toâi bieát ñi laøm vieäc ñuùng gioø moãi ngaøy raát quan troïng, vaø toâi coù theå laøm ñöôïc.	1	2	3	4	5	N/A
10. Toâi xong coâng vieäc ñuùng giôø.	1	2	3	4	5	N/A
11. Toâi laøm theo lôøi chæ daãn cuûa giaùm ñoác / thaøy coâ giaùo cuûa toâi.	1	2	3	4	5	N/A

BIEÄN PHAÙP/NHAÄN XEÙT: _____

_____

STAFF TO SEE INSTRUCTIONS REGARDING ITEMS THAT MUST BE ADDRESSED.

تأريخ تعبئة الإستمارة: _____

يرجى أن تقوم بقراءة كافة البيانات الحياتية الواردة أدناه و قم بتحديد الإجابة التي تنطبق عليك:

الصحة البدنية/الصحة النفسية	كلا، بالإطلاق		نوعاً ما		نعم،	
بالتأكيد لا ينطبق						
1. أعرف كيف يمكنني الحفاظ على خدمات الصحة النفسية التي أستحصل عليها، أو كيفية إستعادتها مرةً أخرى.	1	2	3	4	5	لا ينطبق
2. أعرف كيف يمكنني الحصول على نسخة من ملفي إن إحتجت إلى ذلك.	1	2	3	4	5	لا ينطبق
3. أعرف المشاكل التي أعاني منها، و أعرف كيف يمكنني أن أحصل على المساعدة.	1	2	3	4	5	لا ينطبق
4. أعرف كيف يمكنني أن أجد طبيباً أو معالجاً و كيف يمكنني أن أطلب موعداً.	1	2	3	4	5	لا ينطبق
5. أعرف أسماء الأدوية و العقاقير التي أتناولها.	1	2	3	4	5	لا ينطبق
6. أعرف و أستطيع أن أقول الأسباب التي تدفعني لتناول الأدوية و العقاقير.	1	2	3	4	5	لا ينطبق
7. أعرف كيف يمكنني الحصول على المزيد من الدواء أو العقار كي لا ينفذ.	1	2	3	4	5	لا ينطبق
8. أعرف كيف يمكنني الحصول على المساعدة إن كانت لدي مشاكل في تناول الكحول أو المخدرات.	1	2	3	4	5	لا ينطبق
9. أعرف تأثير تناول المخدرات أو الكحول أو التدخين على جسدي.	1	2	3	4	5	لا ينطبق
10. أعرف كيف أشرح الأعراض الجانبية للعقاقير و الأدوية التي أتناولها.	1	2	3	4	5	لا ينطبق
11. يظهر علي تحكم جيد بالنفس.	1	2	3	4	5	لا ينطبق
12. أعرف بعض الطرق التي تساعدني على التغلب على الضغط النفسي.	1	2	3	4	5	لا ينطبق
13. أعرف كيف يمكنني أن أتجنب الحمل أو الإصابة بالأمراض المنتقلة عن طريق الجنس.	1	2	3	4	5	لا ينطبق

الإجراءات و التعليقات:_____

_____

القدرات الإجتماعيه	كلا، بالإطلاق		نوعا ما		نعم،	
1. خلال وقت فراغي، أجد شيئاً أقوم به لا يسبب لي المشاكل.	1	2	3	4	5	لا
2. لدي نشاطات إيجابية في وقت فراغي أستمتع بالقيام بها.	1	2	3	4	5	لا
3. أشارك بالفعاليات و الأنشطة الجماعية (الرياضة، المجموعات الشبابية، الخ).	1	2	3	4	5	لا
4. أستطيع أن أشرح أحاسيسي.	1	2	3	4	5	لا
5. أستطيع أن أتعامل مع الأمور التي تغضبني من دون صراخ أو ضرب أو تكسير.	1	2	3	4	5	لا
6. أتحدث عن مشاكلي مع عائلتي و أصدقائي.	1	2	3	4	5	لا
7. أرغب بأن يقوم كل من عائلتي و أصدقائي بمساعدتي.	1	2	3	4	5	لا
8. لدي أصدقاء من نفس عمري.	1	2	3	4	5	لا
9. أعرف كيف أكون مؤدباً في التعامل مع الأخرين.	1	2	3	4	5	لا
10. أستطيع أن أقدم (أعرف) نفسي لأشخاص لم ألتقيهم من قبل.	1	2	3	4	5	لا
11. أعرف كيف أكون مستمعاً جيداً، و كيف أقوم بطرح الأسئلة عندما أحتاج لفهم شئ ما	1	2	3	4	5	لا
12. أعرف بعض الطرق التي تجعلني أساعد بها الأخرين الذي يعيشون بقربي.	1	2	3	4	5	لا
13. أستطيع أن أشرح خلفيتي الثقافية.	1	2	3	4	5	لا

الإجراءات و التعليقات:_____

مهارات الحياة اليوميه	كلا، بالإطلاق		نوعا ما		نعم،	
1. أعرف بمن يجب عليَّ الإتصال في الحالات الطارئة.	1	2	3	4	5	لا
2. أحافظ على نظافة أسناني و جسدي.	1	2	3	4	5	لا
3. أعرف كيف أقوم بغسل ملابسي.	1	2	3	4	5	لا
4. أحافظ على غرفة نومي نظيفة.	1	2	3	4	5	لا
5. أعرف كيف أشتري الأشياء من محلات البقالة و المتاجر.	1	2	3	4	5	لا
6. أعرف كيف أحضر طعامي.	1	2	3	4	5	لا
7. أعرف أنواع الطعام التي يجب عليَّ تناولها للحفاظ على صحتي.	1	2	3	4	5	لا
8. أعرف كيف يمكنني الحصول على إجازة قيادة المركبات في كاليفورنيا أو على هوية	1	2	3	4	5	لا
9. أعرف كيف أستخدم حافلة نقل الركاب (الباص) و وسائل النقل العامة الأخرى.	1	2	3	4	5	لا
10. أستطيع أن أدل شخص أخر على محل سكني.	1	2	3	4	5	لا
11. أستطيع أن أعتني بنفسي إن كنت مريضاً أو مصاباً كما و أعرف أين يمكنني الحصول	1	2	3	4	5	لا
12. أعرف كيف يمكنني إصلاح الأشياء في المنزل إن تعطلت.	1	2	3	4	5	لا
13. أعرف ما هي الأشياء التي قد تكون خطرةً في المنزل و أعرف كيف أقوم بتجنب	1	2	3	4	5	لا
14. أعرف كيف يمكنني أن أجد مكان لأسكن فيه.	1	2	3	4	5	لا

الإجراءات و التعليقات:_____

الشؤون الماليه	كلا، بالإطلاق		نوعا ما		نعم، بالتاكيد	لا
1. أعرف كيف أدير أموالي و إستطيع أن أقوم بدفع فواتيري بإستمرار و إنتظام.	1	2	3	4	5	لا
2. أعرف كيف أقوم بكتابة صك (شيك) و أعرف كيف أستعمل بطاقات الإئتمان و البطاقات المصرفية، كما إنني أعرف كيف أقوم بالدفع نقداً و الحصول على باقي الحساب بشكل مضبوط	1	2	3	4	5	لا ينط
3. أعرف كيف أقرر أن أشتري شيئاً ما قبل الأشياء الأخرى إن كنت أحتاج لعدة أشياء و لا أملك المال الكافي لشرائها جميعاً.	1	2	3	4	5	لا ينط

Client:_____

InSyst #:_____

Program:_____

4. أستطيع أن أشرح إيجابيات و سلبيات إستخدام بطاقات الإئتمان.	1	2	3	4	5	لا

الإجراءات و التعليقات:_____

_____

التعليم و التدريب المهني ينطبق	كلا، بالإطلاق		نوعا ما		نعم، بالتاكيد	لا
1. أعرف مالذي يمكن أن يساعدني على تعلم أشياءٍ جديدة.	1	2	3	4	5	لا
2. أعرف مالذي أحب القيام به.	1	2	3	4	5	لا
3. أعرف الأشياء التي أجيد القيام بها.	1	2	3	4	5	لا
4. أعرف ما هي أهدافي الدراسية.	1	2	3	4	5	لا
5. أعرف كيف أحقق أهدافي الدراسية.	1	2	3	4	5	لا
6. أعرف ما هي المهنة التي أرغب بالقيام بها.	1	2	3	4	5	لا
7. أستطيع أن أشرح إحتياجات دراستي أو تدريبي المهني من أجل المهنة التي أرغب	1	2	3	4	5	لا
8. أستطيع أن أعرف ما هي النشاطات و الدروس التي تقدمها مؤسسة ما.	1	2	3	4	5	لا
9. أعرف أن الحضور للعمل في موعده أمر ضروري و أستطيع القيام بذلك.	1	2	3	4	5	لا
10. إنهي واجبات عملي في موعدها.	1	2	3	4	5	لا
11. أتبع توجيهات مديري في العمل أو مدرسي.	1	2	3	4	5	لا

الإجراءات و التعليقات:_____

_____

STAFF TO SEE INSTRUCTIONS REGARDING ITEMS THAT MUST BE ADDRESSED.

Client:_____

InSyst #:_____

Program:_____

TRANSITIONAL YOUTH REFERRAL PLAN - PAPER

2012

WHEN: Children's Mental Health provider is unable to make a routine or successful referral to Adult Mental Health services.

ON WHOM: Any client turning 18 years (or older) who is assessed by a current Children's Mental Health provider to be a candidate for Adult Mental Health services. This form is only to be completed when a direct referral to Adult Mental Health services has not been successful.

COMPLETED BY: Staff providing services.

MODE OF COMPLETION: Transitional Youth Referral Plan form (MHS-605) and filed in the hybrid chart.

REQUIRED ELEMENTS: This is a three part process:

Section I – completed by the referring Children's Mental Health provider

Section II – completed by the Regional Program Coordinator/Designee

Section III – Completed by Regional Program Coordinator /Designee only when the linkage is not successful

TRANSITIONAL YOUTH REFERRAL PLAN

(SEE TRANSITIONAL AGE YOUTH REFERRAL POLICY AND PROCEDURE 01-01-114 FOR MORE DETAILS)

Section I (completed by Children's program with attached referral packet and releases)

Staff Name: _____ Date: _____
Referring Program: _____
Address: _____
Phone Number: _____ Fax Number: _____
Email: _____

Client's Name: _____ Birth Date: _____
Client's Address: _____
Phone Number: _____
Insurance Status: _____
Current Diagnosis: _____
_____
Services currently receiving: _____
_____
Services needed from Adult Mental Health System of Care: _____
_____

I have attempted to refer to the following Adult Mental Health Programs unsuccessfully (include all attempts and outcome);

Program Name: _____
Staff member contacted: _____
Outcome (include reason for denial of admission and referrals given): _____
_____
_____

Program Name: _____
Staff member contacted: _____
Outcome (include reason for denial of admission and referrals given): _____
_____
_____

Other Comments: _____
_____
_____
_____
_____
_____
_____
_____

SECTION II (completed by RPC / designee & provided to Children's provider who initiated request)

Regional Program Coordinator's (RPC) Response:

☐deny services because client does not meet medical necessity criteria
☐youth 18 and over; an assessment will be requested from an adult provider agreeable to the client and family (see specifics below)
☐other (see specifics below)

Program referred to: _____
Staff Name/Contact: _____
Phone Number: _____ Fax Number: _____
_____
_____
_____

RPC / Designee's Name: _____ Date: _____
Phone Number: _____ Fax Number: _____
Email: _____

☐Date response was forwarded to referring party: _____

SECTION III (Completed by RPC when the linkage is not successful. RPC shall coordinate an initial meeting with a multidisciplinary team within two weeks of the initial referral.)

Date of initial meeting: _____

Multidisciplinary Team Members Names and Signatures: _____
_____
_____

Transition Plan Recommendation: _____
_____
_____
_____
_____

Individual to follow up on Plan: _____
Phone Number: _____ Fax Number: _____
Email: _____
☐Date copy of completed form sent to original children's referral source: _____

Youth accepted plan: ☐Yes ☐No ☐Other: _____
_____
(when "no" an alternative shall be identified & same procedure followed)

County of San Diego Health and Human Services Agency (HHSA) Mental Health Services Policies and Procedures MHS General Administration					
Subject:	**Transition Age Youth Referral**	No:	**01-02-212** **Formerly: 01-01-114**		
Reference:	**Mental Health (MH) Youth Transition Service Plan, July 2000**	Page:	**1**	of	**3**

PURPOSE:

To support system of care practice by establishing a process for the transition of clients from County and contracted Children's Mental Health Services (CMHS) when routine referrals have been unsuccessful.

POLICY:

Provide a collaborative process between CMHS and Adult/Older Adult Mental Health (A/OAMH) Services when routine referrals have been unsuccessful to determine an appropriate referral disposition for youth in CMHS who are attaining 18 years (or older in some cases, i.e., AB2726) and who may need continued care in the A/OAMH System of Care.

BACKGROUND:

Youth receiving mental health services in the Children's Mental Health System of Care and who are reaching 18 years of age may require system coordination to successfully transition to the Adult System of Care. To provide integrated services; the following procedure is established when routine referrals have been unsuccessful.

PROCEDURE(S):

1. Youth who need transition planning due to their unique needs but for whom routine referrals have been unsuccessful will be identified by the Children's System of Care staff, either their Case Manager or Care Coordinator, who shall submit a referral packet containing the following information:
   - Referral Form/Cover Letter,
   - 650 Children's Mental Health Assessment and most recent update,
   - Current Five Axis Diagnosis,
   - Youth Transition Evaluation,
   - Mental Status conducted by psychiatrist within the last 45 days,
   - Physical Health Information,
   - Medication Sheet,
   - Service Plan and other plans, e.g., Flexible Service Plan, Therapeutic Behavioral Services (TBS)Plan,
   - Psychological testing done within past year (if available),
   - Individual Education Plan and Individual Transition Plan,

Approved Date: 1/25/10	Approved: Alfredo Aguirre's Signature on File
	Director, Mental Health Services/Designee

- Assessment of financial needs (may need referral to apply for Supplemental Security Income (SSI) six months prior to 18th birthday), and
- Any self evaluations recently given to youth.

2. This packet shall be submitted with releases to the Mental Health Program Coordinator (MHPC) of Adult Mental Health Services in the region where youth resides. The MHPC offices are located at 3255 Camino del Rio South, San Diego, CA 92108.

3. The MHPC will review the packet to determine medical necessity according to Title 9 and the Service Eligibility Policy for the Adult/Older Adult System of Care (to include AB2726 referrals).

4. If the client does not meet medical necessity criteria (or AB2726 criteria), then the client shall be referred back to the referral source for services in the community. If the youth is 18 or over, an assessment will be requested from an adult provider agreeable to the client and family. If the assessment indicates a Medi-Cal beneficiary doesn't meet medical necessity criteria, a Notice of Action Assessment (NOA-A) will be issued, advising him/her of his/her rights to appeal the decision.

5. If a transition plan is agreed upon, the client's CMHS Case Manager or Care Coordinator will attempt to link the client with the targeted service.

6. If the linkage is not successful, the MHPC shall coordinate an initial meeting with a multidisciplinary team within **two weeks** of the initial referral that will include relevant persons that may include, but are not limited to, the following:
   - Youth,
   - Support System (parent, social worker, family members),
   - Children's Mental Health Case Manager and/or Therapist,
   - Current Psychiatrist,
   - Chief of Children's Outpatient Services (or designee),
   - MHPC
   - Adult/Older Adult Case Management Contracting Officer's Technical Representative (COTR) if applicable, or designee,
   - Probation Officer (if applicable), and
   - Educational/Vocational Specialist.

7. Team will review services and options and create a transition plan, complete the Transition Age Youth Referral Plan form, including all signatures. The Care Coordinator will include a copy of the Transition Plan in the medical record. The plan shall identify the individual that will follow up with the transition plan. Should the youth decide this plan is not acceptable, an alternative shall be identified and same procedure followed.

ATTACHMENT(S):

A -Transition Age Youth Referral Form
B -Transition Age Youth Referral Plan

SUNSET DATE:

This policy will be reviewed for continuance on or before November 30, 2012.

AUTHOR/CONTACT ON 11/23/09:

Virginia West

CHILD AND ADOLESCENT MEASUREMENT SYSTEM (CAMS) - PAPER

2012

WHEN:	Provided to caregivers of youth aged 5 – 18+ and to youth 11 and up upon admission, at the authorization/UM cycle, and upon discharge.
NOTE:	Questions and to obtain tools as well as direction for data entry – contact CASRC soce@casrc.org 858-966-7703 ext 3508
ON WHOM:	Clients opened to identified Units/SubUnits.
COMPLETED BY:	Parent/guardian and client and enter score into DES/COSE – these scores are not entered into the EHR.
MODE OF COMPLETION:	CAMS tools and report summaries. Raw data is entered into the DES/SOCE and summary report is generated. File tools and reports in the hybrid chart.
REQUIRED ELEMENTS:	All elements should be completed.
NOTE:	Medication only cases are exempt from completing CAMS.

WHEN: Completed by clinicians upon admission, at the authorization/UM cycle, and upon discharge. To be used by Children's programs only.

NOTE: Clinicians are expected to complete certification on the rating system tool prior to utilizing the tool through the website at:
http://outcomes.fmhi.usf.edu/cfars.cfm

Questions – contact CASRC
soce@casrc.org
858-966-7703 ext 3508

ON WHOM: Clients opened to identified Units/SubUnits.

COMPLETED BY: Clinician.

MODE OF COMPLETION: Data must be entered into the Electronic Health Record. Additionally, this data must be entered into the DES/SOCE.

REQUIRED ELEMENTS: All elements should be completed.

For each category, a level of severity (1-9) must be marked, along with the adjectives or phrases that describe the child's symptoms or assets.

NOTE: Every assessment within the EHR must be completed and final approved in a timely manner. When it is not completed and final approved (red locked), the system will prevent other servers from launching any assessments that contain shared fields. An assessment that is not final approved (status is "open green locked") is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Assessments are not viewed as complete and active until the assessment is final approved (red locked).

Client Name:_____ **Case #:**_____
Date:_____ ***Program Name:**_____

San Diego County Mental Health Services
Children's Functional Assessment rating Scale-CFARS

Copyright held by University of South Florida, John C. Ward, Jr., PhD

Type of Assessment:

- ☐ Admission
- ☐ 3 Months
- ☐ 6 Months
- ☐ 9 Months
- ☐ # Of Months
- ☐ School Based
- ☐ Discharge
- ☐ Admin. Discharge

Admission Date: _____

Problem Severity Ratings

Use the scale below to rate the child/youth's current [last three weeks] of severity for each category.

A rating from 1-9 is required for each major category. Check as many symptoms as indicated under each major category.

1	2	3	4	5	6	7	8	9
No problem	**Less than Slight**	**Slight Problem**	**Slight to Moderate**	**Moderate Problem**	**Moderate to Severe**	**Severe Problem**	**Severe to Extreme**	**Extreme Problem**

***Depression** ____			***Anxiety** ____		
☐Depressed Mood	☐Happy	☐Sleep Problems	☐Anxious/Tense	☐Calm	☐Guilt
☐Sad	☐Hopeless	☐Lacks Energy / Interest	☐Phobic	☐Worried/ Fearful	☐Anti-Anxiety Meds
☐Irritable	☐Withdrawn	☐Anti-Depression Meds	☐Obsessive/Compulsive	☐Panic	
***Hyper activity** ____			***Thought Process** ____		
☐Manic	☐Inattentive	☐Agitated	☐Illogical	☐Delusional	☐Hallucinations
☐Sleep Deficit	☐Overactive / Hyperactive	☐Mood Swings	☐Paranoid	☐Ruminative	☐Command Hallucination
☐Pressured Speech	☐Relaxed	☐Impulsivity	☐Derailed Thinking	☐Loose Associations	☐Intact
☐ADHD Meds	☐Anti-Manic Meds		☐Oriented	☐Disoriented	☐Anti-Psych Meds

***Cognitive Performance** ____		***Medical / Physical** ____		
☐Poor Memory	☐Low Self-Awareness	☐Acute Illness	☐Hypochondria	☐Good Health
☐Poor Attention/Concentration	☐Developmental Disability	☐CNS Disorder	☐Chronic Illness	☐Need Med./Dental Care
☐Insightful	☐Concrete Thinking	☐Pregnant	☐Poor Nutrition	☐Enuretic/ Encopretic
☐Impaired Judgment	☐Slow Processing	☐Eating Disorder	☐Seizures	☐Stress-Related Illness
***Traumatic Stress** ____		***Substance Use** ____		
☐Acute	☐Dreams/Nightmares	☐Alcohol	☐Drug(s)	☐Dependence
☐Chronic	☐Detached	☐Abuse	☐Over Counter Drugs	☐Cravings/Urges
☐Avoidance	☐Repression/Amnesia	☐DUI	☐Abstinent	☐I.V . Drugs
☐Upsetting Memories	☐Hyper Vigilance	☐Recovery	☐Interfere w/Functioning	☐Med. Control

***Interpersonal Relationships** ____			***Behavior in "Home" Setting** ____	
☐Problems w/Friends	☐Diff. Estab./ Maintain		☐Disregards Rules	☐Defies Authority
☐Poor Social Skills	☐Age-Appropriate Group Participation		☐Conflict w/Sibling or Peer	☐Conflict w/Parent or Caregiver
☐Adequate Social Skills	☐Supportive Relationships		☐Conflict w/Relative	☐Respectful
☐Overly Shy			☐Responsible	
***ADL Functioning** ____ (Not Age Appropriate In:)			***Socio-Legal** ____		
☐Handicapped	☐Communication	☐ Self Care	☐Disregards Rules	☐Offense/Property	☐Offense/Person
☐Permanent Disability	☐Hygiene	☐Recreation	☐Fire Setting	☐Probation/Parole	☐Pending Charges
☐No Known Limitations	☐Mobility		☐Dishonest	☐Use/Con Other(s)	☐Incompetent to Proceed
			☐Detention/ Commitment		☐Street Gang Member

***Select:** ☐ **Work** ☐**School** ____			***Danger to Self** ____		
☐Absenteeism	☐Poor Performance	☐Regular	☐Suicidal Ideation	☐Current Plan	☐Recent Attempt
☐Dropped Out	☐Learning disabilities	☐Seeking	☐Past Attempt	☐Self-Injury	☐Self-Mutilation
☐Employed	☐Doesn't Read/Write	☐Tardiness	☐"Risk-Taking" Behavior	☐Serious Self-Neglect	☐Inability to Care for Self
☐Defies Authority	☐Not Employed	☐Suspended			
☐Disruptive	☐Terminated/ Expelled	☐Skips Class			

***Danger to Others** ____		***Security/ Management Needs** ____	
☐Violent Temper	☐Threatens Others	☐Home w/o Supervision	☐Suicide Watch
☐Causes Serious Injury	☐Homicidal Ideation	☐Behavioral Contract	☐Locked Unit
☐Use of Weapons	☐Homicidal Threats	☐Protection from Others	☐Seclusion
☐Assaultive	☐Homicide Attempt	☐Home w/Supervision	☐Run/Escape Risk
☐Cruelty to Animals	☐Accused of Sexual Assault	☐Restraint	☐Involuntary Exam/ Commit.
☐Does not appear dangerous to Others	☐Physically Aggressive	☐Time-Out	☐PRN Medications
		☐Monitored House Arrest	☐One-to-One Supervision

Signature of Staff Member Obtaining Information: _____
Printed Name:_____ Anasazi Staff ID: _____Date: _____
Signature of Staff Entering Information (If different from above): _____
Printed Name:_____ Anasazi Staff ID: _____Date: _____

EYBERG CHILD BEHAVIOR INVENTORY (ECBI) - PAPER

2012

WHEN:	Completed for youth under the age of 5 upon admission and discharge.
NOTE:	Questions and to obtain tools as well as direction for data entry – contact CASRC soce@casrc.org 858-966-7703 ext 3508
ON WHOM:	Clients opened to identified Units/SubUnits.
COMPLETED BY:	Parent/guardian and scored by clinical staff providing service and enter score into DES/SOCE – these scores are not entered into the EHR.
MODE OF COMPLETION:	ECBI tool. Data is entered into the DES/SOCE. File tool in the hybrid chart.
REQUIRED ELEMENTS:	All elements should be completed.

ADULT PROGRAMS

Recovery Markers Questionnaire (RMQ)-Paper

2012

WHEN:	Completed by client at assessment and every 6 months thereafter.
NOTE:	Exception: County Case Management and meds only clients completed at assessment and annually.
ON WHOM:	Clients opened to identified Units/SubUnits.
COMPLETED BY:	Client. If clients require assistance with their RMQ's, staff can help them complete the assessments. Ideally this would be done by a peer or volunteer but any staff could assist.
MODE OF COMPLETION:	Printed out on paper to be completed by client and entered online by program staff. Online website to print out form and enter results: https://homs.ucsd.edu/login.aspx
REQUIRED ELEMENTS:	All elements should be completed.

Recovery Markers Questionnaire (RMQ)

DATE: ☐☐/☐☐/☐☐☐☐ STAFF ID #: ☐☐☐☐☐☐☐☐☐

CLIENT CASE #: ☐☐☐☐☐☐☐☐☐ UNIT/SUB-UNIT: ☐☐☐☐/☐☐☐☐

For each of the following questions, please fill in the answer that is true for you now.	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
My living situation is safe and feels like home to me.	○	○	○	○	○
I have trusted people I can turn to for help.	○	○	○	○	○
I have at least one close mutual (give-and-take) relationship.	○	○	○	○	○
I am involved in meaningful productive activities.	○	○	○	○	○
My psychiatric symptoms are under control.	○	○	○	○	○
I have enough income to meet my needs.	○	○	○	○	○
I am not working, but see myself working within 6 months.	○	○	○	○	○
I am learning new things that are important to me.	○	○	○	○	○
I am in good physical health.	○	○	○	○	○
I have a positive spiritual life/connection to a higher power.	○	○	○	○	○
I like and respect myself.	○	○	○	○	○
I am using my personal strengths skills or talents.	○	○	○	○	○
I have goals I'm working to achieve.	○	○	○	○	○
I have reasons to get out of bed in the morning.	○	○	○	○	○
I have more good days than bad.	○	○	○	○	○
I have a decent quality of life.	○	○	○	○	○
I control the important decisions in my life.	○	○	○	○	○
I contribute to my community.	○	○	○	○	○
I am growing as a person.	○	○	○	○	○
I have a sense of belonging.	○	○	○	○	○
I feel alert and alive.	○	○	○	○	○
I feel hopeful about my future.	○	○	○	○	○
I am able to deal with stress.	○	○	○	○	○
I believe I can make positive changes in my life.	○	○	○	○	○
My symptoms are bothering me less since starting services here	○	○	○	○	○
I deal more effectively with daily problems since starting services here	○	○	○	○	○

	Yes	**No**
I am working part time (less than 35 hours a week)	○	○
I am working full time (35 or more hours per week)	○	○
I am in school	○	○
I am volunteering	○	○
I am in a work training program	○	○
I am seeking employment	○	○
I am retired	○	○
I regularly visit a clubhouse or peer support program	○	○

YOUR INVOLVEMENT IN THE RECOVERY PROCESS: Which of the following statements is most true for you?

○	I have never heard of, or thought about, recovery from psychiatric disability
○	I do not believe I have any need to recover from psychiatric problems
○	I have not had the time to really consider recovery
○	I've been thinking about recovery, but haven't decided yet
○	I am committed to my recovery, and am making plans to take action very soon
○	I am actively involved in the process of recovery from psychiatric disability
○	I was actively moving toward recovery, but now I'm not because: _____
○	I feel that I am fully recovered; I just have to maintain my gains
○	Other (specify):_____

Client could not complete because: ○ language ○ refused ○ unable ○ other (please specify):_____

NOTE: This form can be faxed confidentially to (858) 622-1795 with cover page.

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WHEN:	Completed by clinicians at assessment and every 6 months thereafter.
NOTE:	Exception: County Case Management and meds only clients completed at assessment and annually.
ON WHOM:	Clients opened to identified Units/SubUnits.
COMPLETED BY:	Clinician or Case Manager.
MODE OF COMPLETION:	Online questionnaire. Printed copy can be printed out and kept in the hybrid chart. Online website: https://homs.ucsd.edu/login.aspx
REQUIRED ELEMENTS:	All elements should be completed.

Recovery Scale: IMR Clinician Version

DATE: | | | / | | | / | | | | | STAFF ID #: | | | | | | | | | |

CLIENT CASE #: | | | | | | | | | | UNIT/SUB-UNIT: | | | | | / | | | | |

1. Progress towards personal goals: In the past 3 months, s/he has come up with…

○	○	○	○	○
No personal goals	A personal goal, but has not done anything to finish the goal	A personal goal and made it a little way toward finishing it	A personal goal and has gotten pretty far in finishing the goal	A personal goal and has finished it

2. Knowledge: How much do you feel your client knows about symptoms, treatment, coping strategies (coping methods), and medication?

○	○	○	○	○
Not very much	A little	Some	Quite a bit	A great deal

3. Involvement of family and friends in my mental health treatment: How much are people like family, friends, boyfriends/girlfriends, and other people who are important to your client (outside the mental health agency) involved in his/her mental health treatment?

○	○	○	○	○
Not at all	Only when there is a serious problem	Sometimes, like when things are starting to go badly	Much of the time	A lot of the time and they really help with his/her mental health

4. Contact with people outside of my family: In a normal week, how many times does s/he talk to someone outside of his/her family (like a friend, co-worker, classmate, roommate, etc.)

○	○	○	○	○
0 times/week	1-2 times/week	3-4 times/week	6-7 times/week	8 or more times/week

5. Time in Structured Roles: How much time does s/he spend working, volunteering, being a student, being a parent, taking care of someone else or someone else's house or apartment? That is, how much time does s/he spend in doing activities for or with another person that are expected of him/her? (This would not include self-care or personal home maintenance.)

○	○	○	○	○
2 hours or less/week	3-5 hours/week	6-15 hours/week	16-30 hours/week	More than 30 hours/wk

6. Symptom distress: How much do symptoms bother him/her?

○	○	○	○	○
Symptoms really bother him/her a lot	Symptoms bother him/her quite a bit	Symptoms bother him/her somewhat	Symptoms bother him/her very little	Symptoms don't bother him/her at all

7. Impairment of functioning: How much do symptoms get in the way of him/her doing things that s/he would like to do or need to do?

○	○	○	○	○
Symptoms really get in his/her way a lot	Symptoms get in his/her way quite a bit	Symptoms get in his/her way somewhat	Symptoms get in his/her way very little	Symptoms don't get in his/her way at all

8. Relapse Prevention Planning: Which of the following would best describe what s/he knows and has done in order not to have a relapse?

○	○	○	○	○
Doesn't know how to prevent relapses	Knows a little, but hasn't made a relapse prevention plan	Knows 1 or 2 things to do, but doesn't have a written plan	Knows several things to do, but doesn't have a written plan	Has a written a plan and has shared it with others

9. Relapse of Symptoms: When is the last time s/he had a relapse of symptoms (that is, when his/her symptoms have gotten much worse)?

○	○	○	○	○
Within the last month	In the past 2 to 3 months	In the past 4 to 6 months	In the past 7 to 12 months	Hasn't had a relapse in the past year

NOTE: Complete at Intake and 6 Month Treatment Plan Update

This form can be entered into HOMS at https://homs.ucsd.edu or faxed confidentially to (858) 622-1795.

Recovery Scale: IMR Clinician Version

DATE: | | | / | | | / | | | | | STAFF ID #: | | | | | | | | | |

CLIENT CASE #: | | | | | | | | | | UNIT/SUB-UNIT: | | | | | / | | | | |

10. Psychiatric Hospitalizations: When is the last time s/he has been hospitalized for mental health or substance abuse reasons?

○	○	○	○	○
Within the last month	In the past 2 to 3 months	In the past 4 to 6 months	In the past 7 to 12 months	No hospitalization in the past year

11. Coping: How well do feel your client is coping with his/her mental or emotional illness from day to day?

○	○	○	○	○
Not well at all	Not very well	Alright	Well	Very well

12. Involvement with self-help activities: How involved is s/he in consumer run services, peer support groups, Alcoholics Anonymous, drop-in centers, WRAP (Wellness Recovery Action Plan), or other similar self-help programs?

○	○	○	○	○
Doesn't know about any self-help activities	Knows about some self-help activities, but isn't interested	Is interested in self-help activities, but hasn't participated in the past year	Participates in self-help activities occasionally	Participates in self-help activities regularly

13. Using Medication Effectively: (Don't answer this question if his/her doctor has not prescribed medication). How often does s/he take his/her medication as prescribed?

○	○	○	○	○
Never	Occasionally	About half the time	Most of the time	Every day

____ Check here if the client is not prescribed psychiatric medications.

14. Impairment of functioning through alcohol use: Drinking can interfere with functioning when it contributes to conflict in relationships, or to financial, housing and legal concerns, to difficulty showing up at appointments or focusing during them, or to increases of symptoms. Over the past 3 months, did alcohol use get in the way of his/her functioning?

○	○	○	○	○
Alcohol use really gets his/her way a lot	Alcohol use gets in his/her way quite a bit	Alcohol use gets in his/her way somewhat	Alcohol use gets in his/her way very little	Alcohol use is not a factor in his/her functioning

15. Impairment of functioning through drug use: Using street drugs, and misusing prescription or over-the-counter medication can interfere with functioning when it contributes to conflict in relationships, or to financial, housing and legal concerns, to difficulty showing up at appointments or focusing during them, or to increases of symptoms. Over the past 3 months, did drug use get in the way of his/her functioning?

○	○	○	○	○
Drug use really gets in his/her way a lot	Drug use gets in his/her way quite a bit	Drug use gets in his/her way somewhat	Drug use gets in his/her way very little	Drug use is not a factor in his/her functioning

Please complete the following items if the client is being seen for his/her follow-up treatment planning.

Since the last formal treatment plan update of six months ago…	**Yes**	**No**	**N/A (no goal on client's plan)**
16. has the client demonstrated progress towards achieving his/her **employment goal**?	○	○	○
17. has the client demonstrated progress towards achieving his/her **housing goal**?	○	○	○
18. has the client demonstrated progress towards achieving his/her **education goal**?	○	○	○

NOTE: Complete at Intake and 6 Month Treatment Plan Update

This form can be entered into HOMS at https://homs.ucsd.edu or faxed confidentially to (858) 622-1795.

WHEN:	Completed by clinicians at assessment and quarterly thereafter.
NOTE:	Completed by outpatient clinics only.
ON WHOM:	Clients opened to identified Units/SubUnits.
COMPLETED BY:	Clinician.
MODE OF COMPLETION:	Hand-written.
REQUIRED ELEMENTS:	All elements should be completed.

Milestones of Recovery Scale (MORS)

Date: Client Case # Staff ID #

Unit Subunit

Please select the number that best describes the current (typical for the last two weeks) milestone of recovery for the client listed above. If you have not had any contact (face-to-face or phone) with the client in the last two weeks, do not attempt to rate the client.

- ○ 1. Extreme risk
- ○ 2. High risk/not engaged
- ○ 3. High risk/engaged
- ○ 4. Poorly coping/not engaged
- ○ 5. Poorly coping/engaged
- ○ 6. Coping/rehabilitating
- ○ 7. Early Recovery
- ○ 8. Advanced Recovery

- 1. Extreme risk – These individuals are frequently and recurrently dangerous to themselves or others for prolonged periods. They are frequently taken to hospitals and/or jails or are institutionalized in the state hospital or an IMD. They are unable to function well enough to meet their basic needs even with assistance. It is extremely unlikely that they can be served safely in the community.
- 2. High risk/not engaged- These individuals often are disruptive and are often taken to hospitals and/or jails. They usually have high symptom distress. They are often homeless and may be actively abusing drugs or alcohol and experiencing negative consequences from it. They may have a serious co-occurring medical condition (e.g., HIV, diabetes) or other disability which they are not actively managing. They often engage in high-risk behaviors (e.g., unsafe sex, sharing needles, wandering the streets at night, exchanging sex for drugs or money, fighting, selling drugs, stealing, etc.). They may not believe they have a mental illness and tend to refuse psychiatric medications. They experience great difficulty making their way in the world and are not self-supportive in any way. They are not participating voluntarily in ongoing mental health treatment or are very uncooperative toward mental health providers.
- 3. High risk/engaged – These individuals differ from group 2 only in that they are participating voluntarily and cooperating in ongoing mental health treatment. They are still experiencing high distress and disruption and are low functioning and not self-supportive in any way.

- 4. Poorly coping/not engaged – These individuals are not disruptive. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They may not think they have a mental illness and are unlikely to be taking psychiatric medications. They may have deficits in several activities of daily living and need a great deal of support. They are not participating voluntarily in ongoing mental health treatment and/or are very uncooperative toward mental health providers.
- 5. Poorly coping/engaged – These individuals differ from group 4 only in that they are voluntarily participating and cooperating in ongoing mental health treatment. They may use drugs or alcohol which may be causing moderate but intermittent disruption in their lives. They are generally not a danger to self or others and it is unusual for them to be taken to hospitals and/or jails. They may have moderate to high symptom distress. They are not functioning well and require a great deal of support.
- 6. Coping/rehabilitating – These individuals are abstinent or have minimal impairment from drugs or alcohol. They are rarely being taken to hospitals and almost never being taken to jail. They are managing their symptom distress usually, though not always, through medication. They are actively setting and pursuing some quality of life goals and have begun the process of establishing non-disabled roles. They often need substantial support and guidance but they aren't necessarily compliant with mental health providers. They may be productive in some meaningful roles, but they are not necessarily working or going to school. They may be testing the employment or education waters, but this group also includes individuals who have retired. That is, currently they express little desire to take on (and may actively resist) the increased responsibilities of work or school, but they are more or less content and satisfied with their lives.
- 7. Early Recovery – These individuals are actively managing their mental health treatment to the extent that mental health staff rarely need to anticipate or respond to problems with them. Like group 6, they are rarely using hospitals and are not being taken to jails. Like group 6, they are abstinent or have minimal impairment from drugs or alcohol and they are managing their symptom distress. With minimal support from staff, they are setting, pursuing and achieving many quality of life goals (e.g., work and education) and have established roles in the greater (non-disabled) community. They are actively managing any physical health disabilities or disorders they may have (e.g., HIV, diabetes). They are functioning in many life areas and are very self-supporting or productive in meaningful roles. They usually have a well-defined social support network including friends and/or family.
- 8. Advanced Recovery – These individuals differ from group 7 in that they are completely self-supporting. If they are receiving any public benefits, they are generally restricted to Medicaid or some other form of health benefits or health insurance because their employer does not provide health insurance. While they may still identify themselves as having a mental illness, they are no longer psychiatrically disabled. They are basically indistinguishable from their non-disabled neighbor.

WHEN:	Completed by case manager or clinician at admission and annually thereafter.
NOTE:	Completed by case management, ACT and FSP programs only.
.	
ON WHOM:	Clients opened to identified Units/SubUnits.
COMPLETED BY:	Case Manager or Clinician.
MODE OF COMPLETION:	Hand-written.
REQUIRED ELEMENTS:	All elements should be completed.

LOCUS WORKSHEET
VERSION 2010

Rater Name_____ Date_____

Please check the applicable ratings within each dimension and record the score in the lower right hand corner. Total your score and determine the recommended level of care using either the Placement Grid or the Decision Tree.

I. Risk of Harm
- ☐ 1. Minimal Risk of Harm Criteria _____
- ☐ 2. Low Risk of Harm Criteria _____
- ☐ 3. Moderate Risk of Harm Criteria _____
- ☐ 4. Serious Risk of Harm Criteria _____
- ☐ 5. Extreme Risk of Harm Criteria _____

Score _____

II. Functional Status
- ☐ 1. Minimal Impairment Criteria _____
- ☐ 2. Mild Impairment Criteria _____
- ☐ 3. Moderate Impairment Criteria _____
- ☐ 4. Serious Impairment Criteria _____
- ☐ 5. Severe Impairment Criteria _____

Score _____

III. Co-Morbidity
- ☐ 1. No Co-Morbidity Criteria _____
- ☐ 2. Minor Co-Morbidity Criteria _____
- ☐ 3. Significant Co-Morbidity Criteria _____
- ☐ 4. Major Co-Morbidity Criteria _____
- ☐ 5. Severe Co-Morbidity Criteria _____

Score _____

IV-A. Recovery Environment - Level of Stress
- ☐ 1. Low Stress Environment Criteria _____
- ☐ 2. Mildly Stressful Environment Criteria _____
- ☐ 3. Moderately Stressful Environment Criteria _____
- ☐ 4. Highly Stressful Environment Criteria _____
- ☐ 5. Extremely Stressful Environment Criteria _____

Score _____

IV-B. Recovery Environment - Level of Support
- ☐ 1. Highly Supportive Environment Criteria _____
- ☐ 2. Supportive Environment Criteria _____
- ☐ 3. Limited Support in Environment Criteria _____
- ☐ 4. Minimal Support in Environment Criteria _____
- ☐ 5. No Support in Environment Criteria _____

Score _____

V. Treatment and Recovery History
- ☐ 1. Full Response to Treatment and Recovery Management Criteria _____
- ☐ 2. Significant Response to Treatment and Recovery Management Criteria _____
- ☐ 3. Moderate or Equivocal Response to Treatment and Recovery Management Criteria _____
- ☐ 4. Poor Response to Treatment and Recovery Management Criteria _____
- ☐ 5. Negligible Response to Treatment Criteria _____

Score _____

VI. Engagement
- ☐ 1. Optimal Engagement Criteria _____
- ☐ 2. Positive Engagement Criteria _____
- ☐ 3. Limited Engagement Criteria _____
- ☐ 4. Minimal Engagement Criteria _____
- ☐ 5. Unengaged Criteria _____

Score _____

Composite Score ☐

Level of Care Recommendation ☐

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WHEN:	Completed by clinicians at admission and annually thereafter.
.	
ON WHOM:	Clients opened to identified Units/SubUnits.
COMPLETED BY:	Clinician or Case Manager.
MODE OF COMPLETION:	Hand-written.
REQUIRED ELEMENTS:	All elements should be completed.

Substance Abuse Treatment Scale - Revised (SATS-R)

From *Integrated Treatment for Dual Disorders* by Kim T. Mueser, Douglas L. Noordsy, Robert E. Drake, and Lindy Fox. Copyright 2003 by The Guilford Press: New York.

***Instructions**:* This scale is for assessing a person's stage of substance abuse treatment, not for determining diagnosis. The reporting interval is 6 months. The clinician will document in a progress note what level was chosen and the justification for the choice. The clinician will provide the names, dates, and scores to the Program Manager monthly.

1. ***Pre-engagement.*** The person (not yet a client) does not have contact with a case manager, mental health counselor or substance abuse counselor, and meets criteria for substance abuse or dependence.
2. ***Engagement*** The client has had only irregular contact with an assigned case manager or counselor, and meets criteria for substance abuse or dependence.
3. ***Early Persuasion.*** The client has regular contacts with a case manager or counselor; continues to use the same amount of substances, or has reduced substance use for less than 2 weeks; and meets criteria for substance abuse or dependence.
4. ***Late Persuasion.*** The client has regular contacts with a case manager or counselor; shows evidence of reduction in use for the past 2-4 weeks (fewer drugs, smaller quantities, or both); but still meets criteria for substance abuse or dependence.
5. ***Early Active Treatment.*** The client is engaged in treatment and has reduced substance use for more than the past month, but still meets criteria for substance abuse or dependence during this period of reduction.
6. ***Late Active Treatment.*** The person is engaged in treatment, and has not met criteria for substance abuse or dependence for the past 1-5 months.
7. ***Relapse Prevention.*** The client is engaged in treatment, and has not met criteria for substance abuse or dependence for the past 6-12 months.
8. ***In Remission or Recovery.*** The client has not met criteria for substance abuse or dependence for more than the past year.

Initial Level: ___	Client Plan Update: ___	Client Plan Update: ___
Date_____	Date_____	Date_____
_____	_____	_____
Clinician/Title	Clinician/Title	Clinician/Title

County of San Diego
Health and Human Services Agency
Mental Health Services

SUBSTANCE ABUSE TREATMENT SCALE - REVISED
July 1, 2005

Client: _____

MR/Client ID #: _____

Program: _____

MENTAL HEALTH SERVICES

2012

PLANS

NOTE: Training for the Client Plans and Progress Notes in the EHR began in October 2011. Training will continue throughout the calendar year 2012. Programs not yet trained to use the EHR to document Client Plans and Progress Notes will continue to use paper during the transition and will be held to the same documentation timelines and standards as outlined in the following descriptions unless noted otherwise.

CLIENT PLAN – ADULT MENTAL HEALTH

2012

WHEN:

The initial Client Plan must be completed by the end of the assessment period, which is a maximum of 30 calendar days from opening the client's assignment. Additionally, a Client Plan (CP) shall be completed whenever there is a significant change in the client's planned care.
EFFECTIVE January 1, 2012: All Client Plans can be active for up to 12 months for meds only and meds plus Plans and must be driven by the appropriate authorization process.

Providers are responsible to track the interval covered and assure that there is an active CP in the client chart to cover all services claimed.

Unplanned services such as Crisis Intervention (CI), or inpatient stays do not require a CP. Crisis Residential programs will complete the Client Plan START and Plan may only be active for up to 14 days.

ON WHOM:

All clients with open assignments of thirty days or longer, excluding unplanned services such as CI or inpatient stays.

COMPLETED BY:

Staff delivering services within scope of practice. Must be signed by:
Physician,
Licensed/Waivered Psychologist,
Licensed/Registered/Waivered Social Worker,
Licensed/Registered/Waivered Marriage Family Therapist, or
Registered Nurse, or Nurse Practitioner..
Trainee, Licensed Vocational Nurse, and MHRS can complete but must be co-signed by one of the above.
Co-signatures must be completed within timelines.

MODE OF COMPLETION:

Data must be entered into the Electronic Health Record.

REQUIRED ELEMENTS:

All elements of the CP must be addressed.
For the CP to be active (cover services claimed), it must contain the signature of the client and/or the parent/guardian/care provider AND the service staff listed above (with co-signatures obtained within timelines).
Make sure to cross-reference the date of a progress note to explain:

- when a client's signature is not obtained, why, and level of agreement with participation in treatment, and/or

Efforts shall be made to obtain the client's signature and involvement in CP development. At a later time, when client is available to sign, signature shall be obtained.

Signature updates shall be obtained whenever an addition or modification is made to the CP.

NOTE: A client plan that is not final approved (status is "open green locked") is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Client plans are not viewed as complete and active until the assessment is final approved (red locked) with the appropriate signatures.

WHEN:

The initial Client Plan must be completed by the end of the assessment period, which is a maximum of 30 calendar days from opening the client's assignment. Additionally, a Client Plan (CP) shall be completed whenever there is a significant change in the client's planned care. CP can be active for up to 12 months maximum and must be driven by the appropriate authorization process.

Outpatient Treatment Sessions Authorized (UM – 13/18 sessions):
To be used by Outpatient providers. The CP shall also be rewritten prior to presenting the client's case for Utilization Management (UM). This must occur prior by the end of the first 13 sessions of treatment, and subsequently following the recommendation of the UM authorization. (See UTILIZATION MANAGEMENT REQUEST AND AUTHORIZATION Outpatient Treatment & Case Management Programs Implemented 01-01-2010). CP may be completed up to one month prior to the CP due date.

Day Treatment Intensive:
To be used for Day Treatment Intensive (full and half-day) Programs. The CP must be updated 3 months following the opening of the client's assignment, and every 3 months following. However, the CP must be rewritten annually utilizing the assignment opening date as the guide.

Day Treatment Rehabilitation
To be used for Day Treatment Rehabilitation (full and half-day) Programs. CP must be updated six months following the opening of the client's assignment, and every 6 months following. However, the CP must be rewritten annually utilizing the assignment opening date as the guide.

OP Interval Covered (exception from COTR):
To be used by outpatient programs that do not fall within the parameters outlined above. In this case, the Program Manager must contact the COTR for a waiver to use an interval (months) in place of the UM 13/13 sessions.

Providers are responsible to track the interval covered and assure that there is an active CP in the client chart to cover all services claimed.

Unplanned services such as Crisis Intervention (CI), or inpatient stays do not require a CP. Beginning at the conclusion of the MH MIS Client Plan training, medication only cases will require a CP and each

medication only CP can be active for a maximum of 12 months. Therapeutic Behavioral Services complete the Client Plan TBS.

ON WHOM: All clients with open assignments of thirty days or longer, excluding unplanned services such as CI or inpatient stays.

COMPLETED BY: Staff delivering services within scope of practice. Must be signed by:

Physician,
Licensed/Waivered Psychologist,
Licensed/Registered/Waivered Social Worker,
Licensed/Registered/Waivered Marriage Family Therapist, or
Registered Nurse.
Trainee and MHRS can complete but must be co-signed by one of the above.

Co-signatures must be completed within timelines.

MODE OF COMPLETION: Data must be entered into the Electronic Health Record.

REQUIRED ELEMENTS: All elements of the CP must be addressed.

For the CP to be active (cover services claimed), it must contain the signature of the client and/or the parent/guardian/care provider AND the service staff listed above (with co-signatures obtained within timelines).

Make sure to cross-reference the date of a progress note to explain:

- when a client's signature is not obtained, why, and level of agreement with participation in treatment, and/or
- when client is a Dependent of the Court and therefore no signature is obtained, and/or
- when the parent/guardian/care provider is not available to sign the CP but provides verbal authorization, and/or
- when explaining why a guardian's signature is not obtained for any other reason.

Efforts shall be made to obtain the guardian's signature and involvement in CP development. At a later time, when guardian is available to sign, signature shall be obtained.

Signature updates shall be obtained whenever an addition or modification is made to the CP.

NOTE: When a client receives TBS services during the assignment, a copy of the TBS Client Plan should be available in the electronic health record.

A client plan that is not final approved (status is "open green locked") is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Client plans are not viewed as complete and active until the assessment is final approved (red locked) with the appropriate signatures.

CLIENT PLAN – THERAPEUTIC BEHAVIORAL SERVICES

2012

WHEN:

A Therapeutic Behavioral Services (TBS) Client Plan must be completed prior to the TBS Coach(s) start date. At least a minimal Client Plan shall be completed by the end of the initial authorization period (thirty days from the contractor's opening the client's assignment).

Additionally, a Client Plan shall be reviewed and updated at each monthly review meeting and whenever there is a significant change in the client's planned care. When services continue to be needed, the Client Plan shall also be rewritten at the third month review meeting.

The TBS case manager shall provide a copy of all Client Plans and updates to the County TBS facilitator.

ON WHOM:

All clients who receive TBS services. Occasionally there are clients who are approved for TBS, but for some reason do not actually receive services. These clients are not required to have a TBS Client Plan.

COMPLETED BY:

Staff delivering services within scope of practice. Must be signed by:

Physician,
Licensed/Waivered Psychologist,
Licensed/Registered/Waivered Social Worker,
Licensed/Registered/Waivered Marriage Family Therapist, or
Registered Nurse.
Trainee and MHRS can complete but must be co-signed by one of the above.

Co-signatures must be completed within timelines.

The case manager for the TBS contractor is required to complete a Client Plan for each client. The case manager shall have the TBS team sign the TBS Client Plan and offer a copy of the plan to each team member, which includes the client. The County facilitator approves services based on the TBS Client Plan.

MODE OF COMPLETION:

Data must be entered into the Electronic Health Record.

REQUIRED ELEMENTS:

All elements of the CP must be addressed.
For the CP to be active (cover services claimed), it must contain the Following signatures: Client (Cross reference date of progress note when no client signature is present. Progress notes outlines reason.)

1. Parent/Guardian (caretaker)
2. Specialty Mental Health Provider – SMHP (therapist)
3. TBS Case Manager – Contractor
4. TBS Facilitator – County
5. TBS Coach(s)

NOTE: When a client receives TBS services, a copy of the TBS Client Plan should be provided to the Specialty Mental Health Provider (SMHP).

County of San Diego Mental Health Services
CLIENT PLAN

Client Name: _____ **Case #**: _____

Program Name: _____ **Unit/SubUnit**: _____

Client Plan Begin Date: _____ **Client Plan End Date**: _____

PLANNING TIERS

Strengths (Identify client strength from the strengths table. These are what the client/support persons/staff identifies as general strengths for the client. Identify strength and individualize)

Strength: _____
Strength: _____
Strength: _____
Strength: _____

Area of Need # 1 (Identify need from the instructions. This is an area in which a level of impairment is identified by the client/support persons/staff. Identify the need and individualize)

Need: _____
_____
_____
_____

Goal for Need #1 (Identify the goal from the identified need. This is the broad goal that the client wants to achieve in treatment. Whenever possible the client's own words should be documented. Identify the goal and individualize)

Goal: _____
_____
_____
_____

Applied Strength for Goal/Need # 1 (Identify one of the strengths above. This is a specific strength that the client can utilize to achieve this goal. Identify the applied strength and individualize)

Applied Strength: _____
_____
_____
_____

County of San Diego Mental Health Services
CLIENT PLAN

Client Name: _____ **Case #**: _____

Objective # ____ for Goal/Need # ____ (Identify the objective from the identified goal. There are no limits on the number of objectives for each goal – be sure to number each objective to match the designated goal. These are action steps that the client will focus on in order to achieve his/her goal. Identify the objective and individualize)

Objective: _____

_____

_____

Interventions for Objective # _____ (Identify each intervention. Service codes are considered interventions – each intervention my be individualized for how it will be used to assist the client achieve his/her goal)

Intervention: _____

_____

Intervention: _____

_____

Intervention: _____

_____

Intervention: _____

_____

Intervention: _____

_____

Intervention: _____

_____

Intervention: _____

_____

Intervention: _____

_____

Intervention: _____

_____

Intervention: _____

_____

County of San Diego Mental Health Services
CLIENT PLAN

Client Name: _____ **Case #**: _____

Area of Need # ____ (Identify need from the instructions. This is an area in which a level of impairment is identified by the client/support persons/staff. Identify the need and individualize)

Need: _____
_____
_____
_____

Goal for Need # ____ (Identify the goal from the identified need. This is the broad goal that the client wants to achieve in treatment. Whenever possible the client's own words should be documented. Identify the goal and individualize)

Goal: _____
_____
_____
_____

Applied Strength for Goal/Need # ____ (Identify one of the strengths above. This is a specific strength that the client can utilize to achieve this goal. Identify the applied strength and individualize)

Applied Strength: _____
_____
_____
_____

(Objective/s and Interventions on following page)

County of San Diego Mental Health Services
CLIENT PLAN

Client Name: _____ **Case #**: _____

Explained in client's primary language of: _____

Explained in guardian's primary language of: _____

Client offered a copy of the plan:

Yes ___

No _____(if no, document reason): _____

_____

SIGNATURES:

Client:_____ **Date**: _____

☐ **Refused to sign** **Explanation:** _____

Parent/Guardian Signature: _____ **Date:** _____

Conservator Signature: _____ **Date:** _____

Other Signature: _____ **Date:** _____

Signature of Staff Requiring Co-Signature:

_____ **Date:** _____

_____ **ID Number:** _____

Printed Name

***Signature of Staff Completing/Accepting Client Plan:**

_____ **Date:** _____

_____ **ID Number:** _____

Printed Name

STRENGTHS TABLE

Ability to Form and Maintain Relationships
Ability to Manage Activities of Daily Living
Ability to Navigate Public Transportation
Academic History
Accepts Feedback from Others
Accepts Responsibility
Actively Seeking Information about Change
Adaptable
Adaptive Distancing/Resistance
Adequate Decision-making Skills
Adventurous
Affectionate
Alert
Ambitious
Artistic
Athletic
Attentive
Bold
Brave
Calm
Capable
Charming
Cheerful
Clean-cut Appearance
Communicates Well
Communication
CompassionAlturism
Competent
Conscientious
Considerate
Creative
Curious
Daily Living Skills
Dependable
Drug-free
Easy-going Appearance
Effective
Efficient
Empathy/Caring
Energetic
Enterprising
Exercises Regularly
Faith/Spiritulatiy
Flexibility
Forgiving
Goal-Directed/Motivated
Hard-working
Has Transportation
Hobbies/Special Interests
Honest
Humble
Independent
Insight/Critical Thinking
Intelligent
Internal Locus of Control
Kind
Likeable
Living Environment
Long-term Sobriety in Past
Loyal
Maintaining Personal Changes
Manages Finances Adequately

STRENGTHS TABLE

Mature
Meticulous
Open to Change
Open-minded
Optimism/Hope
Organized
Other
Outgoing
Patient
Peaceful
Physically Active
Physically Attractive
Physically Healthy
Physically Strong
Physically Tough
Physically Versatile
Planning
Positive Identity
Positive Relationship with Parents
Positive Relationship with Siblings
Practices Good Nutrition
Prayerful
Previous Positive Experience in Treatment
Professional Demeanor
Quick Learner
Reflective
Relaxed
Religious
Reserved
Resourcefulness
Responsible
Responsiveness
Self-Awareness
Self-Efficacy/Mastery
Self-sacrificing
Sense of Empowerment
Sense of Humor
Sense of Meaning
Sensitive
Serious
Stable Environment
Stable Family Life
Steady Demeanor
Strong Cultural Identity
Support System
Sympathetic
Tactful
Taking Action for Personal Change
Tolerant
Trusting
Trustworthy
Utilizes Agreed-Upon Treatment Recommendations
Verbal
Vocational Skills
Wants to Work
Warm Personality
Wholesome
Wise
Work History

Area of Need: Abuse/Addiction Substance/Non-Substance
Goal: Increase freedom from abuse/addiction
Objectives:

Accept Feedback from Others
Access Resources/Natural Support in Comm
Address Abuse/Neglect Issues
Address Cultural Identity Issues
Address Gender Identity/Practices Issues
Address Outstanding Financial Issues
Address Outstanding Legal Issues
Address Sexual Issues
Assessment of Risk
Attend 12-Step Meetings Regularly
Attend Classes
Complete Treatment as Planned
Complete Withdrawal/Detox Phase
Comply with Drug/Alcohol Screens
Comply with Laws
Develop Artistic/Creative Activities
Develop Coping Skills to Manage Issue(s)
Develop Recreational/Leisure Activities
Develop Wellness Recovery Action Plan
Develop/Follow Routine or Structure
Develop/Practice Personal Safety Skills
Develop/Use Relapse Prevention Plan
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Encourage Connection to PrimaryCare Prov
Engage with Peer Recovery Resources
Evaluate/Change/Stabilize LivingSituatio
Expand and Utilize Support System
Explore Spirituality
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Irrational Thoughts
Identify Medication Side Effects
Identify Patterns in Compulsive Behavior
Identify Personal Strengths
Identify Physical Health Care Needs
Identify Resources/Natural Support in Com
Identify Triggers for Behavior
Improve Self Identity/Esteem
Increase Periods of Abstinence
Learn to Identify Symptoms
Learn/Follow Housing Rules
Learn/Pract Appropriate Emotional Expres
Learn/Practice Alternative Behaviors
Learn/Practice Anger Management
Learn/Practice Communication Skills
Learn/Practice Community Living Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Good Nutrition
Learn/Practice Good Sleep Habits
Learn/Practice Healthy Boundaries
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Maintaining Friendships
Learn/Practice Medication Adherence
Learn/Practice Money Management
Learn/Practice Organization and Planning
Learn/Practice Pers Daily Living Skills
Learn/Practice Problem Solving Skills
Learn/Practice Regular Exercise
Learn/Practice Relaxation Techniques
Learn/Practice Safe Sex
Learn/Practice Self-Monitoring
Learn/Practice Social Skills
Learn/Practice Symptom Management
Linkage to PCP or Comm'ty Medical Clinic
Obtain Medication Services
Other
Participate in Recovery Classes
Participate in Reunification Plan
Reduce Avoidance and Isolation
Reduce Compulsive/Addictive Behavior
Reduce Family Stress
Reduce Frequency/Intensity of Symptoms
Reduce Hopelessness and Desperation
Reduce Hospitalization
Reduce Incarceration
Reduce Individual Level of Stress
Reduce Physical Aggression
Reduce Risk of Harm
Reduce Self-Injurious Behaviors
Reduce Social Anxiety
Reduce Use of Drugs Including Alcohol
Schedule/Attend Neuropsychological Eval
Understand Need for Medication

Area of Need: Basic Needs – Food, Clothing, Shelter

Goal: Meet basic needs

Objectives:

Access Resources/Natural Support in Comm
Address Outstanding Financial Issues
Address Outstanding Legal Issues
Adjust to Life-Cycle Transition
Assess Situation and Identify Needs
Attend Classes
Complete Treatment as Planned
Comply with Laws
Cooperate with Criminal Justice System
Develop Coping Skills to Manage Issue(s)
Develop/Follow Routine or Structure
Develop/Practice Personal Safety Skills
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Evaluate/Change/Stabilize LivingSituatio
Expand and Utilize Support System
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Personal Strengths
Identify Resources/Natural Support in Com
Identify Start/Root of Issue
Interact Appropriately with Others
Learn/Follow Housing Rules
Learn/Practice Alternative Behaviors
Learn/Practice Communication Skills
Learn/Practice Community Living Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Good Nutrition
Learn/Practice Healthy Boundaries
Learn/Practice Identifying Needs
Learn/Practice Money Management
Learn/Practice Organization and Planning
Learn/Practice Pers Daily Living Skills
Learn/Practice Problem Solving Skills
Learn/Practice Public Transport Skills
Learn/Practice Symptom Management
Obtain Financial Assistance/Benefits
Other
Participate in Medical/Dental Treatment
Participate in Mental Health Treatment
Provide for Own Food/Clothing/Shelter
Secure/Hold Stable Employment

Area of Need: Education
Goal: Improve educational status
Objectives:

Accept Feedback from Others
Access Resources/Natural Support in Comm
Assess Interests and Abilities
Assess Situation and Identify Needs
Attend Classes
Clarify Educational Needs
Complete Treatment as Planned
Develop Coping Skills to Manage Issue(s)
Develop/Follow Routine or Structure
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Evaluate/Change Education Environment
Exhibit Appropriate School Behavior
Expand and Utilize Support System
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Issues Regarding Separation
Identify Personal Strengths
Identify Resources/Natural Support in Com
Identify Start/Root of Issue
Identify Triggers for Behavior
Identify/Improve Technical Skills
Improve Self Identity/Esteem
Interact Appropriately with Others
Learn to Identify Symptoms
Learn/Pract Appropriate Emotional Expres
Learn/Practice Alternative Behaviors
Learn/Practice Anger Management
Learn/Practice Communication Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Good Sleep Habits
Learn/Practice Healthy Boundaries
Learn/Practice Identifying Needs
Learn/Practice Maintaining Friendships
Learn/Practice Medication Adherence
Learn/Practice Organization and Planning
Learn/Practice Pers Daily Living Skills
Learn/Practice Problem Solving Skills
Learn/Practice Public Transport Skills
Learn/Practice Relaxation Techniques
Learn/Practice Self-Monitoring
Learn/Practice Social Skills
Learn/Practice Symptom Management
Other
Participate in Education/Training Progrm
Reduce Avoidance and Isolation
Reduce Frequency/Intensity of Symptoms
Reduce Individual Level of Stress
Reduce Physical Aggression
Reduce Reaction to Trauma Triggers
Reduce Risk of Harm
Reduce Self-Injurious Behaviors
Reduce Social Anxiety
Schedule/Attend Neuropsychological Eval
Understand Need for Medication

Area of Need: Emotional-Behavioral/Psychiatric
Goal: Improve/Maintain functioning
Objectives:

Accept Feedback from Others
Access Resources/Natural Support in Comm
Address Abuse/Neglect Issues
Address Cultural Identity Issues
Address Gender Identity/Practices Issues
Address Sexual Issues
Adjust to Life-Cycle Transition
Assessment of Risk
Complete Treatment as Planned
Develop Artistic/Creative Activities
Develop Coping Skills to Manage Issue(s)
Develop Cultural Identity/Practices
Develop Recreational/Leisure Activities
Develop Wellness Recovery Action Plan
Develop/Follow Routine or Structure
Develop/Practice Personal Safety Skills
Develop/Use Journaling
Develop/Use Relapse Prevention Plan
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Encourage Connection to PrimaryCare Prov
Engage with Peer Recovery Resources
Evaluate/Change Education Environment
Evaluate/Change Work Environment
Evaluate/Change/Stabilize LivingSituatio
Exhibit Appropriate School Behavior
Expand and Utilize Support System
Explore Spirituality
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Irrational Thoughts
Identify Issues Regarding Separation
Identify Medication Side Effects
Identify Patterns in Compulsive Behavior
Identify Personal Strengths
Identify Physical Health Care Needs
Identify Resources/Natural Support in Com
Identify Source(s) of Family Conflict
Identify Start/Root of Issue
Identify Triggers for Behavior
Identify/Acknowledge Trauma
Identify/Obtain Health Insurance
Improve Child-Parent Interactions
Improve Family Relationships
Improve Self Identity/Esteem
Increase Quality Time in Relationship
Interact Appropriately with Others
Learn to Identify Symptoms
Learn/Pract Appropriate Emotional Expres
Learn/Practice Alternative Behaviors
Learn/Practice Anger Management
Learn/Practice Communication Skills
Learn/Practice Community Living Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Good Nutrition
Learn/Practice Good Sleep Habits
Learn/Practice Healthy Boundaries
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Maintaining Friendships
Learn/Practice Medication Adherence
Learn/Practice Organization and Planning
Learn/Practice Pain Management
Learn/Practice Pers Daily Living Skills
Learn/Practice Problem Solving Skills
Learn/Practice Public Transport Skills
Learn/Practice Regular Exercise
Learn/Practice Relaxation Techniques
Learn/Practice Safe Sex
Learn/Practice Self-Monitoring
Learn/Practice Social Skills
Learn/Practice Symptom Management
Linkage to PCP or Comm'ty Medical Clinic
Obtain Medication Services
Other
Participate in Mental Health Treatment
Participate in Recovery Classes
Participate in Reunification Plan
Provide for Own Food/Clothing/Shelter
Reduce Avoidance and Isolation
Reduce Compulsive/Addictive Behavior
Reduce Family Stress
Reduce Frequency/Intensity of Symptoms
Reduce Hopelessness and Desperation
Reduce Hospitalization
Reduce Incarceration
Reduce Individual Level of Stress
Reduce Physical Aggression
Reduce Reaction to Trauma Triggers
Reduce Risk of Harm
Reduce Self-Injurious Behaviors
Reduce Social Anxiety
Reduce Use of Drugs Including Alcohol
Schedule/Attend Neuropsychological Eval
Understand Need for Medication

Area of Need: Family Stress
Goal: Reduce family stress
Objectives:

Accept Feedback from Others
Access Resources/Natural Support in Comm
Address Abuse/Neglect Issues
Address Cultural Identity Issues
Address Gender Identity/Practices Issues
Address Outstanding Financial Issues
Address Outstanding Legal Issues
Address Sexual Issues
Adjust to Life-Cycle Transition
Assess Situation and Identify Needs
Assessment of Risk
Attend 12-Step Meetings Regularly
Attend Classes
Complete Treatment as Planned
Comply with Laws
Cooperate with Criminal Justice System
Develop Coping Skills to Manage Issue(s)
Develop Cultural Identity/Practices
Develop Recreational/Leisure Activities
Develop Wellness Recovery Action Plan
Develop/Follow Routine or Structure
Develop/Practice Personal Safety Skills
Develop/Use Journaling
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Evaluate/Change/Stabilize LivingSituatio
Exhibit Appropriate School Behavior
Expand and Utilize Support System
Explore Spirituality
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Issues Regarding Separation
Identify Personal Strengths
Identify Physical Health Care Needs
Identify Resources/Natural Support in Com
Identify Source(s) of Family Conflict
Identify Start/Root of Issue
Identify Triggers for Behavior
Identify/Acknowledge Trauma
Identify/Obtain Health Insurance
Improve Care Giving Skills
Improve Child-Parent Interactions
Improve Family Relationships
Increase Quality Time in Relationship
Interact Appropriately with Others
Learn/Pract Appropriate Emotional Expres
Learn/Practice Acculturation
Learn/Practice Alternative Behaviors
Learn/Practice Anger Management
Learn/Practice Communication Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Good Sleep Habits
Learn/Practice Healthy Boundaries
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Medication Adherence
Learn/Practice Money Management
Learn/Practice Organization and Planning
Learn/Practice Pers Daily Living Skills
Learn/Practice Problem Solving Skills
Learn/Practice Relaxation Techniques
Learn/Practice Self-Monitoring
Learn/Practice Social Skills
Learn/Practice Symptom Management
Other
Participate in Recovery Classes
Participate in Reunification Plan
Reduce Avoidance and Isolation
Reduce Compulsive/Addictive Behavior
Reduce Family Stress
Reduce Frequency/Intensity of Symptoms
Reduce Hospitalization
Reduce Incarceration
Reduce Individual Level of Stress
Reduce Physical Aggression
Reduce Reaction to Trauma Triggers
Reduce Risk of Harm
Reduce Self-Injurious Behaviors
Reduce Use of Drugs Including Alcohol
Secure/Hold Stable Employment

Area of Need: Financial
Goal: Improve financial situation
Objectives:

Access Resources/Natural Support in Comm
Address Outstanding Financial Issues
Address Outstanding Legal Issues
Assess Situation and Identify Needs
Assessment of Risk
Attend 12-Step Meetings Regularly
Attend Classes
Clarify Job Dissatisfaction
Complete Treatment as Planned
Develop Coping Skills to Manage Issue(s)
Develop/Follow Routine or Structure
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Evaluate/Change Work Environment
Evaluate/Change/Stabilize LivingSituatio
Expand and Utilize Support System
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Patterns in Compulsive Behavior
Identify Personal Strengths
Identify Resources/Natural Support in Com
Identify Start/Root of Issue
Learn/Practice Alternative Behaviors
Learn/Practice Avoiding Impulsivity
Learn/Practice Communication Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Healthy Boundaries
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Medication Adherence
Learn/Practice Money Management
Learn/Practice Organization and Planning
Learn/Practice Problem Solving Skills
Learn/Practice Self-Monitoring
Learn/Practice Symptom Management
Obtain Financial Assistance/Benefits
Obtain Legal Representation/Services
Other
Participate in Mental Health Treatment
Provide for Own Food/Clothes/Shelter
Reduce Compulsive/Addictive Behavior
Reduce Family Stress
Reduce Individual Level of Stress
Reduce Risk of Harm
Reduce Use of Drugs Including Alcohol
Secure/Hold Stable Employment

Area of Need: Identity Issues: Cultural/Gender
Goal: Reduce stress of identity issues
Objectives:

Access Resources/Natural Support in Comm
Address Abuse/Neglect Issues
Address Cultural Identity Issues
Address Gender Identity/Practices Issues
Address Sexual Issues
Adjust to Life-Cycle Transition
Complete Treatment as Planned
Develop Artistic/Creative Activities
Develop Coping Skills to Manage Issue(s)
Develop Recreational/Leisure Activities
Develop/Practice Personal Safety Skills
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Evaluate/Change Work Environment
Evaluate/Change/Stabilize LivingSituatio
Exhibit Appropriate School Behavior
Expand and Utilize Support System
Explore Spirituality
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Personal Strengths
Identify Resources/Natural Support in Com
Identify Source(s) of Family Conflict
Identify/Acknowledge Trauma
Improve Care Giving Skills
Improve Self Identity/Esteem
Learn/Pract Appropriate Emotional Expres
Learn/Practice Alternative Behaviors
Learn/Practice Communication Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Healthy Boundaries
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Maintaining Friendships
Learn/Practice Medication Adherence
Learn/Practice Problem Solving Skills
Learn/Practice Safe Sex
Learn/Practice Social Skills
Learn/Practice Symptom Management
Other
Reduce Avoidance and Isolation
Reduce Compulsive/Addictive Behavior
Reduce Individual Level of Stress
Reduce Self-Injurious Behaviors
Reduce Social Anxiety
Reduce Use of Drugs Including Alcohol
Understand Need for Medication

Area of Need: Intimate Relationships
Goal: Improve intimate relationships
Objectives:

Accept Feedback from Others
Access Resources/Natural Support in Comm
Address Abuse/Neglect Issues
Address Cultural Identity Issues
Address Gender Identity/Practices Issues
Address Outstanding Financial Issues
Address Outstanding Legal Issues
Address Sexual Issues
Adjust to Life-Cycle Transition
Assess Situation and Identify Needs
Assessment of Risk
Attend 12-Step Meetings Regularly
Complete Treatment as Planned
Comply with Laws
Cooperate with Criminal Justice System
Develop Coping Skills to Manage Issue(s)
Develop Recreational/Leisure Activities
Develop/Follow Routine or Structure
Develop/Practice Personal Safety Skills
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Expand and Utilize Support System
Explore Spirituality
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Issues Regarding Separation
Identify Personal Strengths
Identify Resources/Natural Support in Com
Identify Source(s) of Family Conflict
Identify Start/Root of Issue
Identify Triggers for Behavior
Identify/Acknowledge Trauma
Improve Care Giving Skills
Improve Child-Parent Interactions
Improve Family Relationships
Improve Self Identity/Esteem
Increase Quality Time in Relationship
Interact Appropriately with Others
Learn/Pract Appropriate Emotional Expres
Learn/Practice Alternative Behaviors
Learn/Practice Anger Management
Learn/Practice Communication Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Healthy Boundaries
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Maintaining Friendships
Learn/Practice Medication Adherence
Learn/Practice Money Management
Learn/Practice Organization and Planning
Learn/Practice Problem Solving Skills
Learn/Practice Safe Sex
Learn/Practice Self-Monitoring
Learn/Practice Social Skills
Learn/Practice Symptom Management
Other
Participate in Reunification Plan
Reduce Avoidance and Isolation
Reduce Compulsive/Addictive Behavior
Reduce Family Stress
Reduce Frequency/Intensity of Symptoms
Reduce Hopelessness and Desperation
Reduce Individual Level of Stress
Reduce Physical Aggression
Reduce Reaction to Trauma Triggers
Reduce Risk of Harm
Reduce Self-Injurious Behaviors
Reduce Social Anxiety
Reduce Use of Drugs Including Alcohol
Secure/Hold Stable Employment
Understand Need for Medication

Area of Need: Lack of Physical Health Care
Goal: Obtain physical health care
Objectives:

Access Resources/Natural Support in Comm
Address Outstanding Financial Issues
Adjust to Life-Cycle Transition
Assessment of Risk
Complete Physical Exam and/or Lab Work
Complete Treatment as Planned
Develop Coping Skills to Manage Issue(s)
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Encourage Connection to PrimaryCare Prov
Engage with Peer Recovery Resources
Expand and Utilize Support System
Identify/Access Community Activities
Identify Barriers
Identify Physical Health Care Needs
Identify Resources/Natural Support in Com
Identify/Obtain Health Insurance
Learn/Practice Communication Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Identifying Needs
Learn/Practice Problem Solving Skills
Learn/Practice Public Transport Skills
Linkage to PCP or Comm'ty Medical Clinic
Obtain Medical/Dental Exam
Obtain Medication Services
Other
Reduce Family Stress
Reduce Individual Level of Stress
Reduce Risk of Harm

Area of Need: Legal
Goal: Fulfill legal obligations
Objectives:

Accept Feedback from Others
Access Resources/Natural Support in Comm
Address Outstanding Financial Issues
Address Outstanding Legal Issues
Assess Situation and Identify Needs
Assessment of Risk
Complete Treatment as Planned
Comply with Drug/Alcohol Screens
Comply with Laws
Cooperate with Criminal Justice System
Develop Coping Skills to Manage Issue(s)
Develop/Follow Routine or Structure
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Expand and Utilize Support System
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Patterns in Compulsive Behavior
Identify Personal Strengths
Identify Resources/Natural Support in Com
Identify Triggers for Behavior
Learn/Pract Appropriate Emotional Expres
Learn/Practice Alternative Behaviors
Learn/Practice Anger Management
Learn/Practice Avoiding Impulsivity
Learn/Practice Communication Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Medication Adherence
Learn/Practice Money Management
Learn/Practice Organization and Planning
Learn/Practice Problem Solving Skills
Learn/Practice Self-Monitoring
Learn/Practice Social Skills
Learn/Practice Symptom Management
Obtain Legal Representation/Services
Other
Reduce Family Stress
Reduce Frequency/Intensity of Symptoms
Reduce Hopelessness and Desperation
Reduce Incarceration
Reduce Individual Level of Stress
Reduce Physical Aggression
Reduce Risk of Harm
Reduce Use of Drugs Including Alcohol

Area of Need: Meaningful Role (tied to self-determination)
Goal: Increase self-determination
Objectives:

Accept Feedback from Others
Access Resources/Natural Support in Comm
Address Abuse/Neglect Issues
Address Cultural Identity Issues
Address Gender Identity/Practices Issues
Address Sexual Issues
Adjust to Life-Cycle Transition
Assess Interests and Abilities
Assess Situation and Identify Needs
Clarify Educational Needs
Clarify Job Dissatisfaction
Complete Treatment as Planned
Comply with Laws
Develop Artistic/Creative Activities
Develop Coping Skills to Manage Issue(s)
Develop Recreational/Leisure Activities
Develop Wellness Recovery Action Plan
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Evaluate/Change Education Environment
Evaluate/Change Work Environment
Evaluate/Change/Stabilize LivingSituatio
Expand and Utilize Support System
Explore Spirituality
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Personal Strengths
Identify Resources/Natural Support in Com
Identify Start/Root of Issue
Identify/Acknowledge Trauma
Identify/Improve Technical Skills
Improve Self Identity/Esteem
Increase Quality Time in Relationship
Learn/Practice Community Living Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Healthy Boundaries
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Job Skills
Learn/Practice Medication Adherence
Learn/Practice Pers Daily Living Skills
Learn/Practice Problem Solving Skills
Learn/Practice Regular Exercise
Learn/Practice Relaxation Techniques
Learn/Practice Self-Monitoring
Learn/Practice Symptom Management
Other
Participate in Education/Training Progrm
Reduce Avoidance and Isolation
Reduce Frequency/Intensity of Symptoms
Reduce Hospitalization
Reduce Incarceration
Reduce Use of Drugs Including Alcohol
Secure/Hold Stable Employment

Area of Need: Neglect/Abuse
Goal: Reduce threat to safety
Objectives:

Access Resources/Natural Support in Comm
Address Abuse/Neglect Issues
Address Cultural Identity Issues
Address Gender Identity/Practices Issues
Address Sexual Issues
Adjust to Life-Cycle Transition
Assess Situation and Identify Needs
Assessment of Risk
Attend Classes
Complete Physical Exam and/or Lab Work
Complete Treatment as Planned
Comply with Laws
Cooperate with Criminal Justice System
Develop Coping Skills to Manage Issue(s)
Develop Wellness Recovery Action Plan
Develop/Follow Routine or Structure
Develop/Practice Personal Safety Skills
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Evaluate/Change/Stabilize LivingSituatio
Exhibit Appropriate School Behavior
Expand and Utilize Support System
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Issues Regarding Separation
Identify Personal Strengths
Identify Resources/Natural Support in Com
Identify Source(s) of Family Conflict
Identify Start/Root of Issue
Identify Triggers for Behavior
Identify/Acknowledge Trauma
Improve Care Giving Skills
Improve Child-Parent Interactions
Improve Family Relationships
Interact Appropriately with Others
Learn/Follow Housing Rules
Learn/Pract Appropriate Emotional Expres
Learn/Practice Alternative Behaviors
Learn/Practice Anger Management
Learn/Practice Communication Skills
Learn/Practice Community Living Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Healthy Boundaries
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Medication Adherence
Learn/Practice Problem Solving Skills
Learn/Practice Safe Sex
Learn/Practice Self-Monitoring
Learn/Practice Symptom Management
Other
Participate in Recovery Classes
Participate in Reunification Plan
Reduce Family Stress
Reduce Frequency/Intensity of Symptoms
Reduce Hospitalization
Reduce Incarceration
Reduce Individual Level of Stress
Reduce Physical Aggression
Reduce Risk of Harm
Reduce Self-Injurious Behaviors
Reduce Use of Drugs Including Alcohol
Understand Need for Medication

Area of Need: Neurological/Brain Impairment
Goal: Improve daily functioning
Objectives:

Accept Feedback from Others
Access Resources/Natural Support in Comm
Address Cultural Identity Issues
Address Outstanding Legal Issues
Address Sexual Issues
Adjust to Life-Cycle Transition
Attend Classes
Complete Treatment as Planned
Develop Artistic/Creative Activities
Develop Coping Skills to Manage Issue(s)
Develop Recreational/Leisure Activities
Develop Wellness Recovery Action Plan
Develop/Follow Routine or Structure
Develop/Practice Personal Safety Skills
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Encourage Connection to PrimaryCare Prov
Engage with Peer Recovery Resources
Exhibit Appropriate School Behavior
Expand and Utilize Support System
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Medication Side Effects
Identify Personal Strengths
Identify Physical Health Care Needs
Identify Resources/Natural Support in Com
Identify Start/Root of Issue
Identify Triggers for Behavior
Improve Child-Parent Interactions
Increase Quality Time in Relationship
Interact Appropriately with Others
Learn to Identify Symptoms
Learn/Follow Housing Rules
Learn/Pract Appropriate Emotional Expres
Learn/Practice Alternative Behaviors
Learn/Practice Anger Management
Learn/Practice Communication Skills
Learn/Practice Community Living Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Good Nutrition
Learn/Practice Good Sleep Habits
Learn/Practice Healthy Boundaries
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Maintaining Friendships
Learn/Practice Medication Adherence
Learn/Practice Money Management
Learn/Practice Organization and Planning
Learn/Practice Pers Daily Living Skills
Learn/Practice Problem Solving Skills
Learn/Practice Public Transport Skills
Learn/Practice Regular Exercise
Learn/Practice Relaxation Techniques
Learn/Practice Safe Sex
Learn/Practice Self-Monitoring
Learn/Practice Social Skills
Learn/Practice Symptom Management
Linkage to PCP or Comm'ty Medical Clinic
Other
Participate in Mental Health Treatment
Participate in Recovery Classes
Provide for Own Food/Clothing/Shelter
Reduce Avoidance and Isolation
Reduce Compulsive/Addictive Behavior
Reduce Frequency/Intensity of Symptoms
Reduce Hospitalization
Reduce Incarceration
Reduce Individual Level of Stress
Reduce Physical Aggression
Reduce Risk of Harm
Reduce Self-Injurious Behaviors
Reduce Social Anxiety
Reduce Use of Drugs Including Alcohol
Schedule/Attend Neuropsychological Eval
Understand Need for Medication

Area of Need: Physical Health Problems
Goal: Improve physical health
Objectives:

Access Resources/Natural Support in Comm
Address Cultural Identity Issues
Address Gender Identity/Practices Issues
Address Outstanding Financial Issues
Address Sexual Issues
Adjust to Life-Cycle Transition
Assessment of Risk
Attend Classes
Complete Physical Exam and/or Lab Work
Complete Treatment as Planned
Develop Coping Skills to Manage Issue(s)
Develop Recreational/Leisure Activities
Develop Wellness Recovery Action Plan
Develop/Follow Routine or Structure
Develop/Use Relapse Prevention Plan
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Encourage Connection to PrimaryCare Prov
Engage with Peer Recovery Resources
Expand and Utilize Support System
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Medication Side Effects
Identify Patterns in Compulsive Behavior
Identify Personal Strengths
Identify Physical Health Care Needs
Identify Resources/Natural Support in Com
Identify Start/Root of Issue
Identify Triggers for Behavior
Identify/Obtain Health Insurance
Learn to Identify Symptoms
Learn/Practice Alternative Behaviors
Learn/Practice Communication Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Good Nutrition
Learn/Practice Good Sleep Habits
Learn/Practice Identifying Needs
Learn/Practice Medication Adherence
Learn/Practice Pain Management
Learn/Practice Pers Daily Living Skills
Learn/Practice Problem Solving Skills
Learn/Practice Regular Exercise
Learn/Practice Relaxation Techniques
Learn/Practice Safe Sex
Learn/Practice Self-Monitoring
Learn/Practice Symptom Management
Linkage to PCP or Comm'ty Medical Clinic
Obtain Medical/Dental Exam
Obtain Medication Services
Other
Participate in Medical/Dental Treatment
Reduce Compulsive/Addictive Behavior
Reduce Frequency/Intensity of Symptoms
Reduce Hospitalization
Reduce Individual Level of Stress
Reduce Risk of Harm
Reduce Self-Injurious Behaviors
Reduce Use of Drugs Including Alcohol
Schedule/Attend Neuropsychological Eval
Understand Need for Medication

Area of Need: Potential for Harm Self/Others
Goal: Reduce potential for harm
Objectives:

Accept Feedback from Others
Access Resources/Natural Support in Comm
Address Abuse/Neglect Issues
Address Sexual Issues
Assessment of Risk
Attend Classes
Complete Physical Exam and/or Lab Work
Complete Treatment as Planned
Cooperate with Criminal Justice System
Develop Coping Skills to Manage Issue(s)
Develop Wellness Recovery Action Plan
Develop/Follow Routine or Structure
Develop/Practice Personal Safety Skills
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Evaluate/Change/Stabilize LivingSituatio
Expand and Utilize Support System
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Personal Strengths
Identify Resources/Natural Support in Com
Identify Source(s) of Family Conflict
Identify/Acknowledge Trauma
Improve Care Giving Skills
Improve Child-Parent Interactions
Improve Family Relationships
Learn to Identify Symptoms
Learn/Pract Appropriate Emotional Expres
Learn/Practice Alternative Behaviors
Learn/Practice Anger Management
Learn/Practice Communication Skills
Learn/Practice Community Living Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Good Sleep Habits
Learn/Practice Healthy Boundaries
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Medication Adherence
Learn/Practice Pers Daily Living Skills
Learn/Practice Problem Solving Skills
Learn/Practice Regular Exercise
Learn/Practice Relaxation Techniques
Learn/Practice Safe Sex
Learn/Practice Self-Monitoring
Learn/Practice Symptom Management
Other
Participate in Education/Training Progrm
Participate in Mental Health Treatment
Participate in Reunification Plan
Reduce Compulsive/Addictive Behavior
Reduce Family Stress
Reduce Frequency/Intensity of Symptoms
Reduce Hospitalization
Reduce Incarceration
Reduce Individual Level of Stress
Reduce Physical Aggression
Reduce Risk of Harm
Reduce Self-Injurious Behaviors
Reduce Use of Drugs Including Alcohol
Understand Need for Medication

Area of Need: Social Functioning
Goal: Improve social functioning
Objectives:

Accept Feedback from Others
Access Resources/Natural Support in Comm
Address Abuse/Neglect Issues
Address Cultural Identity Issues
Address Gender Identity/Practices Issues
Address Outstanding Financial Issues
Address Sexual Issues
Adjust to Life-Cycle Transition
Assess Interests and Abilities
Assess Situation and Identify Needs
Assessment of Risk
Attend Classes
Complete Treatment as Planned
Develop Artistic/Creative Activities
Develop Coping Skills to Manage Issue(s)
Develop Cultural Identity/Practices
Develop Recreational/Leisure Activities
Develop Wellness Recovery Action Plan
Develop/Follow Routine or Structure
Develop/Practice Personal Safety Skills
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Evaluate/Change Education Environment
Evaluate/Change Work Environment
Evaluate/Change/Stabilize LivingSituatio
Exhibit Appropriate School Behavior
Expand and Utilize Support System
Explore Spirituality
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Irrational Thoughts
Identify Issues Regarding Separation
Identify Medication Side Effects
Identify Personal Strengths
Identify Resources/Natural Support in Com
Identify Source(s) of Family Conflict
Identify Start/Root of Issue
Identify Triggers for Behavior
Identify/Acknowledge Trauma
Improve Care Giving Skills
Improve Child-Parent Interactions
Improve Family Relationships
Improve Self Identity/Esteem
Increase Quality Time in Relationship
Interact Appropriately with Others
Learn to Identify Symptoms
Learn/Follow Housing Rules
Learn/Pract Appropriate Emotional Expres
Learn/Practice Acculturation
Learn/Practice Alternative Behaviors
Learn/Practice Anger Management
Learn/Practice Communication Skills
Learn/Practice Community Living Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Good Sleep Habits
Learn/Practice Healthy Boundaries
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Maintaining Friendships
Learn/Practice Medication Adherence
Learn/Practice Organization and Planning
Learn/Practice Pers Daily Living Skills
Learn/Practice Problem Solving Skills
Learn/Practice Public Transport Skills
Learn/Practice Regular Exercise
Learn/Practice Relaxation Techniques
Learn/Practice Safe Sex
Learn/Practice Self-Monitoring
Learn/Practice Social Skills
Learn/Practice Symptom Management
Other
Participate in Education/Training Progrm
Participate in Mental Health Treatment
Participate in Recovery Classes
Participate in Reunification Plan
Reduce Avoidance and Isolation
Reduce Compulsive/Addictive Behavior
Reduce Family Stress
Reduce Frequency/Intensity of Symptoms
Reduce Hospitalization
Reduce Incarceration
Reduce Individual Level of Stress
Reduce Physical Aggression
Reduce Risk of Harm
Reduce Self-Injurious Behaviors
Reduce Social Anxiety
Reduce Use of Drugs Including Alcohol
Understand Need for Medication

Area of Need: Spiritual
Goal: Increase inner peace
Objectives:

Accept Feedback from Others
Access Resources/Natural Support in Comm
Address Cultural Identity Issues
Address Gender Identity/Practices Issues
Address Outstanding Financial Issues
Address Outstanding Legal Issues
Address Sexual Issues
Adjust to Life-Cycle Transition
Attend Classes
Complete Treatment as Planned
Develop Artistic/Creative Activities
Develop Coping Skills to Manage Issue(s)
Develop Recreational/Leisure Activities
Develop/Follow Routine or Structure
Develop/Practice Personal Safety Skills
Develop/Use Journaling
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Exhibit Appropriate School Behavior
Expand and Utilize Support System
Explore Spirituality
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Personal Strengths
Identify Resources/Natural Support in Com
Identify Source(s) of Family Conflict
Identify Start/Root of Issue
Identify Triggers for Behavior
Identify/Acknowledge Trauma
Improve Self Identity/Esteem
Increase Quality Time in Relationship
Interact Appropriately with Others
Learn to Identify Symptoms
Learn/Pract Appropriate Emotional Expres
Learn/Practice Alternative Behaviors
Learn/Practice Anger Management
Learn/Practice Communication Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Maintaining Friendships
Learn/Practice Medication Adherence
Learn/Practice Organization and Planning
Learn/Practice Problem Solving Skills
Learn/Practice Regular Exercise
Learn/Practice Relaxation Techniques
Learn/Practice Self-Monitoring
Learn/Practice Symptom Management
Other
Participate in Reunification Plan
Reduce Avoidance and Isolation
Reduce Compulsive/Addictive Behavior
Reduce Family Stress
Reduce Frequency/Intensity of Symptoms
Reduce Hospitalization
Reduce Incarceration
Reduce Individual Level of Stress
Reduce Physical Aggression
Reduce Reaction to Trauma Triggers
Reduce Risk of Harm
Reduce Self-Injurious Behaviors
Reduce Social Anxiety
Understand Need for Medication

Area of Need: Stress
Goal: Reduce Stress
Objectives:

Accept Feedback from Others
Access Resources/Natural Support in Comm
Address Abuse/Neglect Issues
Address Cultural Identity Issues
Address Gender Identity/Practices Issues
Address Outstanding Financial Issues
Address Outstanding Legal Issues
Address Sexual Issues
Adjust to Life-Cycle Transition
Assessment of Risk
Attend Classes
Clarify Job Dissatisfaction
Complete Physical Exam and/or Lab Work
Complete Treatment as Planned
Cooperate with Criminal Justice System
Develop Artistic/Creative Activities
Develop Coping Skills to Manage Issue(s)
Develop Recreational/Leisure Activities
Develop Wellness Recovery Action Plan
Develop/Follow Routine or Structure
Develop/Practice Personal Safety Skills
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Encourage Connection to PrimaryCare Prov
Engage with Peer Recovery Resources
Evaluate/Change Education Environment
Evaluate/Change Work Environment
Evaluate/Change/Stabilize LivingSituatio
Exhibit Appropriate School Behavior
Expand and Utilize Support System
Explore Spirituality
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Issues Regarding Separation
Identify Personal Strengths
Identify Physical Health Care Needs
Identify Resources/Natural Support in Com
Identify Source(s) of Family Conflict
Identify Triggers for Behavior
Identify/Acknowledge Trauma
Identify/Improve Technical Skills
Improve Care Giving Skills
Improve Child-Parent Interactions
Improve Family Relationships
Improve Self Identity/Esteem
Increase Quality Time in Relationship
Interact Appropriately with Others
Learn to Identify Symptoms
Learn/Follow Housing Rules
Learn/Pract Appropriate Emotional Expres
Learn/Practice Alternative Behaviors
Learn/Practice Anger Management
Learn/Practice Communication Skills
Learn/Practice Community Living Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Good Nutrition
Learn/Practice Good Sleep Habits
Learn/Practice Healthy Boundaries
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Maintaining Friendships
Learn/Practice Medication Adherence
Learn/Practice Money Management
Learn/Practice Organization and Planning
Learn/Practice Pers Daily Living Skills
Learn/Practice Problem Solving Skills
Learn/Practice Regular Exercise
Learn/Practice Relaxation Techniques
Learn/Practice Safe Sex
Learn/Practice Self-Monitoring
Learn/Practice Social Skills
Learn/Practice Symptom Management
Linkage to PCP or Comm'ty Medical Clinic
Other
Participate in Mental Health Treatment
Participate in Recovery Classes
Participate in Reunification Plan
Reduce Avoidance and Isolation
Reduce Compulsive/Addictive Behavior
Reduce Family Stress
Reduce Frequency/Intensity of Symptoms
Reduce Hospitalization
Reduce Incarceration
Reduce Individual Level of Stress
Reduce Physical Aggression
Reduce Reaction to Trauma Triggers
Reduce Risk of Harm
Reduce Self-Injurious Behaviors
Reduce Social Anxiety
Reduce Use of Drugs Including Alcohol
Secure/Hold Stable Employment
Understand Need for Medication

Area of Need: Trauma
Goal: Reduce effects of trauma
Objectives:

Accept Feedback from Others
Access Resources/Natural Support in Comm
Address Abuse/Neglect Issues
Address Cultural Identity Issues
Address Gender Identity/Practices Issues
Address Sexual Issues
Assessment of Risk
Attend Classes
Complete Physical Exam and/or Lab Work
Complete Treatment as Planned
Develop Coping Skills to Manage Issue(s)
Develop Wellness Recovery Action Plan
Develop/Follow Routine or Structure
Develop/Practice Personal Safety Skills
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Expand and Utilize Support System
Explore Spirituality
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Irrational Thoughts
Identify Issues Regarding Separation
Identify Patterns in Compulsive Behaviors
Identify Personal Strengths
Identify Physical Health Care Needs
Identify Resources/Natural Support in Com
Identify Source(s) of Family Conflict
Identify Triggers for Behavior
Identify/Acknowledge Trauma
Improve Care Giving Skills
Improve Child-Parent Interactions
Improve Family Relationships
Improve Self Identity/Esteem
Interact Appropriately with Others
Learn to Identify Symptoms
Learn/Pract Appropriate Emotional Expres
Learn/Practice Alternative Behaviors
Learn/Practice Anger Management
Learn/Practice Communication Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Healthy Boundaries
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Maintaining Friendships
Learn/Practice Medication Adherence
Learn/Practice Problem Solving Skills
Learn/Practice Relaxation Techniques
Learn/Practice Self-Monitoring
Learn/Practice Symptom Management
Other
Participate in Reunification Plan
Reduce Avoidance and Isolation
Reduce Compulsive/Addictive Behavior
Reduce Family Stress
Reduce Frequency/Intensity of Symptoms
Reduce Hospitalization
Reduce Incarceration
Reduce Individual Level of Stress
Reduce Physical Aggression
Reduce Reaction to Trauma Triggers
Reduce Risk of Harm
Reduce Self-Injurious Behaviors
Reduce Social Anxiety
Reduce Use of Drugs Including Alcohol
Schedule/Attend Neuropsychological Eval
Understand Need for Medication

Area of Need: Vocational/Employment
Goal: Improve vocational status
Objectives:

Accept Feedback from Others
Access Resources/Natural Support in Comm
Address Outstanding Financial Issues
Adjust to Life-Cycle Transition
Attend Classes
Clarify Educational Needs
Clarify Jon Dissatisfaction
Complete Treatment as Planned
Develop Coping Skills to Manage Issue(s)
Develop/Follow Routine or Structure
Educate Parent/Guardian
Educate Spouse/Partner
Educate Support System/Family/Friends
Engage with Peer Recovery Resources
Evaluate/Change Education Environment
Evaluate/Change Work Environment
Exhibit appropriate School Behavior
Expand and Utilize Support System
Identify/Access Community Activities
Identify Alternative Behaviors
Identify Barriers
Identify Behavioral Consequences
Identify Personal Strengths
Identify Recources/NaturalSupport in Com
Identify/Improve Technical Skills
Learn/Pract Appropriate Emotioanl Expres
Learn/Practice Alternative Behaviors
Learn/Practice Anger Management
Learn/Practice Communication Skills
Learn/Practice Coping Skills
Learn/Practice Goal Setting
Learn/Practice Good Sleep Habits
Learn/Practice Healthy Boundaries
Learn/Practice Healthy Disagreement
Learn/Practice Identifying Needs
Learn/Practice Job Skills
Learn/Practice Medication Adherence
Learn/Practice Money Management
Learn/Practice Organization and Planning
Learn/Practice Pers Daily Living Skills
Learn/Practice Problem Solving Skills
Learn/Practice Transport Skills
Learn/Practice Self-Monitoring
Learn/Practice Social Skills
Learn/Practice Symptom Management
Other
Participate in Education/Training Program
Reduce Frequency/Intensity of Symptoms
Reduce Individual Level of Stress
Reduce Physical Aggression
Reduce Social Anxiety
Reduce Use of Drugs Including Alcohol
Secure/Hold Stable Employment
Understand Need for Medication

MY SAFETY PLAN –CHILD and ADULT– Paper

2012

WHEN: "My Safety Plan" should be completed when there is risk or concern that crisis intervention may be needed. It should be updated throughout treatment as needed.

ON WHOM: As clinically indicated.

COMPLETED BY: Client, guardian (if applicable), and service provider. Formulation of the plan is a collaborative effort. A copy of the plan will be given to the client and/or caregiver.

MODE OF COMPLETION: Handwritten or typed. A hard copy shall be filed in paper hybrid chart. Document the completion of the plan in the Electronic Health Record (EHR).

REQUIRED ELEMENTS: All elements are required.

NOTE:

- "My Safety Plan" is intended to be a helpful resource for clients and families during times of crises or risk of crises. This form replaced the "Crisis Prevention Plan" and "Crisis Recovery Plan". Additionally, it shall be completed in lieu of a "Safety Contract" and "No Harm Contract".

- In reference to item #2 on "My Safety Plan", include both client's words/preferences, and clinically appropriate interventions, as well as helpful things client identified in their WRAP Plan if he/she completed one.

- In reference to item #3 on "My Safety Plan", list as many relevant supports as available. Do not limit to just professional supports.

- In reference to item #5 on "My Safety Plan", list professional supports such as the client's counselor, Care Coordinator, and the program's on-call counselor after business hours.

My Safety Plan

We understand that there may be times when life feels overwhelming. During these times, sometimes people feel hopeless or think things will never get better. Your safety is our highest priority and our goal is to help you stay safe when difficult times arise. The items below help to identify when you may need more support and action steps you and the people in your life can take to help.

1. Early warning signs that tell me I may need help are:

   _____

   _____

2. Things I can do to help myself during these times are:

   _____

   _____

3. People who can support me (family, friends, community, etc.) are (list name, relationship and phone numbers):

Name	Relationship	Phone Number

4. Things my support persons can do to help are:

   _____

   _____

5. Members of my treatment team I can call:

Name	Relationship	Phone Number

6. If the above resources are not available, other community resources available to me are (check all that apply):

   ☐ **The Access & Crisis Line at 888-724-7240**. Available 24 hours/7 days a week. Languages other than English are available.

   ☐ **911**. If you feel you are in immediate danger of emergency, do not hesitate to call. Ask if PERT is available.

   ☐ **San Diego County Emergency Psychiatric Unit at 619-692-8200, located at 3853 Rosecrans Street, San Diego, CA 92110.** Available to adults for emergency psychiatric assistance.

   ☐ **San Diego County Emergency Screening Unit at 619-421-6900, located at 730 Medical Center Court, Chula Vista, CA, 91911.** Available to children and adolescents for emergency psychiatric assistance.

   ☐ **Youth Talkline at 1-877-450-5463.** For children and teens seeking peer support and referrals concerning substance abuse or mental health issues for themselves or someone they care about. Mon – Fri, 12 p.m. – 6 p.m.

   ☐ **Consumer-to-Consumer WARM Line at 1-800-930-9276 (WARM).** Daily: 3:30 p.m.—11:00 p.m.

   ☐ **National Suicide Prevention Hotline at 1-800-273-8255 (TALK).** A 24-hour hotline available to anyone in crisis.

   ☐ **SD County Behavioral Health Emergency Response Plan (ERP).** This is a document for me to fill out and keep with me. It has important information to share with emergency response teams if they are called to assist me. (If checked, this indicates you've completed an ERP).

   ☐ **Other** (list name and phone #) _____

Hospital or Crisis House of choice: (list name and phone #): _____

I understand that the staff is trying to help me and I will do my best to stay safe .

Client Signature: _____ Date Signed: _____

Parent/Guardian Signature: _____ Date Signed: _____

Revised: Jan 2013

Mi Plan de Seguridad

Entendemos que puede haber etapas en la vida cuando uno se siente agobiado. Durante estas etapas, a veces la gente se siente sin esperanza o piensa que las cosas nunca se mejorarán. Tu seguridad es nuestra prioridad más alta y nuestra meta es ayudarte a mantenerte seguro cuando ocurran estas etapas. Los siguientes puntos ayudan a identificar los momentos en los que podrías necesitar más apoyo, y los pasos de acción que las personas en tu vida pueden tomar para ayudarte.

1. Primera señales de alarma que me indican que puedo necesitar ayuda son: _____

2. Las cosas que puedo hacer para ayudarme durante estos tiempos son: _____

3. Las personas que pueden apoyarme (familia, amigos, comunidad, etc.) son (escribe el nombre, relación y números de teléfonos):

Nombre	Relación	Número de Teléfono

4. Las cosas que mis personas de apoyo pueden hacer para auxiliarme: _____

5. Los miembros de mi equipo de tratamiento (consejero, siquiatra, terapeuta) que puedo llamar:

Nombre	Relación	Número de Teléfono

6. Si los recursos mencionados arriba no están a mi disposición, otros recursos de la comunidad que están a mi disposición son (seleccione todos lo que apliquen):

☐ **Línea de Acceso y Crisis al 1-888-724-7240.** Disponible las 24 horas/7 días a la semana. Otros idiomas disponibles.

☐ **911.** Si usted siente que está en peligro inmediato, no dude en llamar. Pregunte si PERT (Equipo de Respuesta Frente a una Emergencia Psiquiátrica) está disponible.

☐ **Unidad/Hospital Psiquiátrica del Condado de San Diego al 619-692-8200, localizada en 3853 Rosecrans Street, San Diego, CA, 92110.** Disponible para Adultos para asistencia psiquiátrica de emergencia.

☐ **Unidad de Chequeo de Urgencia del Condado de San Diego al 619-421-6900, localizada en 730 Medical Center Court, Chula Vista, Ca, 91911.** Disponible para niños y adolescentes para asistencia psiquiátrica de emergencia.

☐ **Línea de Apoyo para Jóvenes *Peer2Peer* al 1-877-450-5463.** Para niños y adolescentes que buscan apoyo y recursos acerca de abuso de drogas o salud mental para ellos mismos o para sus seres queridos. Lunes a Viernes, 12 pm – 6 pm.

☐ **Línea de WARM (Apoyo al Consumidor) al 1-800-930-9276 (WARM).** Diario: 3:30 pm – 11 pm.

☐ **Línea Nacional de Prevención de Suicidio al 1-800-273-8255 (TALK).** Una línea de acceso disponible a cualquier persona en crisis las 24 horas.

☐ **Plan de Respuesta a un Urgencia de la Salud Conductual del Condado de San Diego (ERP).** Este es un documento para que yo lo llene y conserve conmigo. Contiene la información importante para compartir con el equipo de respuesta a una emergencia si son llamados para asistirme. (De ser seleccionado, esto indica que usted ha completado un ERP).

☐ **Otro**: **Centro de Crisis Rady Children's al 1-760-730-5900**. Asistencia de salud mental urgente para personas menores de 17 años. Lunes a Viernes, 12 pm – 8 pm.

☐ **Otros** (escriba el nombre y número de teléfono): _____

Hospital o Casa de Crisis de su preferencia: (escriba el nombre y # de teléfono): _____

Entiendo que el personal de este programa trata de ayudarme y haré todo lo posible por mantenerme seguro/a.

Nombre del Cliente: _____ **Firma del Cliente:**_____ **Fecha:** _____

Firma del Padre/ Tutor Legal:_____ **Fecha:** _____

INITIAL DAY PROGRAM REQUEST, CONTINUED DAY PROGRAM REQUES
SPECIALTY MENTAL HEALTH SERVICES DPR

2012

Day Programs & Ancillary Services

NOTE:

Forms are generated by OptumHealth (Optum) which became the Point of Authorization for Day Intensive and Day Rehabilitation Programs (Half or Full) on 01-01-03. Outpatient Mental Health Services (MHS) offered on the same day (ancillary services) must also be authorized by Optum, with the CMBR component still subject to outpatient Utilization Management/Review (UM/UR). Medication only cases, TBS, and unplanned services such as Crisis Intervention (CI) are excluded from the Optum and UM/UR authorization process.

In circumstances where retroactive authorization is needed, it may be granted through Optum. Department of Mental Health (DMH) will not accept claims that are over one year old, and it takes up to 3 months for services to clear the system and be claimed. Thus, retroactive authorization should not be requested for services more than 9 months in the past. The Program Monitor must be notified via e-mail when submitting a retroactive authorization request.

Clients placed through Child Welfare continue to require a quarterly report to be completed and submitted to the Child Welfare Worker – the DPR will not suffice.

WHEN:

- Prior authorization is required for Day Programs that occur more than five days per week.
- Initial authorization for Day Programs (and therefore ancillary programs) must be obtained by the seventh visit or twenty days after the Day Provider opens a client episode in EHR (whichever comes first).
- **Day Intensive must be re-authorized every three months.** Utilizing the Continued Day Program Request Form. Submitted to OPTUM at least 15 days before previous authorization expires. (For Day Intensive an authorization cycle may look like: Initial DPR 1/1/06 - 3/31/06, Continued DPR 4/1/06 - 6/30/06, etc.)
- **Day Rehabilitation must be re-authorized every six months.** Utilizing the Continued Day Program Request Form. Submitted to OPTUM at least 15 days before previous authorization expires. (For Day Rehab an authorization cycle may look like: Initial DPR 1/1/06 - 5/31/06, Continued DPR 6/1/06 - 11/30/06, etc.)
- Outpatient providers (ancillary services) treating a client who is enrolled in a Day Program must obtain authorization through the Day Program Provider. Authorization is only required for Mental Health Services (not for Medication Support, TBS, Crisis Intervention, or CMBR which follow outpatient UR procedures). Ancillary providers must submit the Specialty Mental Health Services DPR Form to the Day Provider at least fifteen days prior to the end of the previous authorization so all forms can be submitted to OPTUM.

INITIAL DAY PROGRAM REQUEST, CONTINUED DAY PROGRAM REQUES
SPECIALTY MENTAL HEALTH SERVICES DPR

2012

ON WHOM:

All day program clients. Only DPRs for MediCal clients are to be submitted to Optum for review.

Outpatient (ancillary services) clients who are simultaneously enrolled in a Day Program obtain authorization through the Day Provider (until the client leaves the day treatment program). All providers are to ensure no duplication of service occurs.

COMPLETED BY:

Request submitted by: MD, Clinical or waivered Psychologist, licensed or waivered LCSW, licensed or waivered MFT, RN (with Masters Degree and psychiatric specialty), or trainee with co-signature by LPHA.

MODE OF COMPLETION:

Legibly handwritten, typed, or word-processed on most current OPTUM form(s). Authorization request forms are available on line at www.Optumpublicsector.com/sandiego/sdforms.htm

REQUIRED ELEMENTS:

Staff requesting services must complete all sections of the form that correspond with the requested authorization period.

- Adult, Child and Youth Ancillary Service Necessity Criteria
- CFARS
- Signatures

NOTE:

DPR forms were revised in August 2005, and implemented by October 1, 2005. DPR now include the CFARS which provides clinicians a standardized measure to evaluate client's progress. Starting in July 1, 2005 the CFARS findings are entered and tracked by the SOCE Data Entry System at the program level and downloaded to the SOCE team quarterly. This is done at intake, every 3 or 6 months (depending on authorization cycle), and at discharge (using the discharge summary MHS-653 form). Having a standardized measure allows for tracking and trending treatment effectiveness on a client and program level, and provides a move towards evidence based treatment.

DPRs should be filed in the medical record in the Plans section, or be accessible upon request. Optum will generate an Authorization Letter and send it to the Provider at the address provided to Optum within 14 business days. If a Provider does not receive the Letter within the 14 day timeline and is unable to access the information in EHR, please contact OPTUM directly. Authorization Letters should be attached to the corresponding DPR.

This form should be used to request authorization of payment for **Specialty Mental Health Services.**	**County of San Diego Mental Health Plan** **Specialty Mental Health Services DPR** RECEIVED:	**Form must be submitted to OptumHealth Public Sector by client's Day Program provider. OptumHealth Public Sector cannot accept this form if submitted by Specialty Mental Health Services Provider**

CLIENT INFORMATION *******CONFIDENTIAL*******

Client Name: (*First & Last*)	Client Anasazi ID #:	Date of Birth

DAY PROGRAM INFORMATION

Legal Entity & Day Program Name: *Please print clearly*

_____Phone: :_____

Day Program Unit#_____Subunit# _____

SPECIALTY MENTAL HEALTH SERVICES PROGRAM INFORMATION

Legal Entity & Specialty Mental Health Program Name: *Please print clearly*

_____Phone: :_____

Specialty Mental Health Program Uni#_____Subunit# _____

REQUEST FOR AUTHORIZATION of Specialty Mental Health Services delivered by Organizational County Contracted providers on the same day as Day Program Services.

*** Treatment must include coordination with the other professionals treating client. Authorization is required only for ancillary services delivered on the same day client receives Day Program Services. Ancillary Services delivered to client in an Intensive Day Program require continued authorization within 3 months. Ancillary Services delivered to client in a Day Rehab program require continued authorization within 6 months. Medication Management, Case Management, TBS, and Crisis Intervention Services do not require authorization. ***

Complete the request by writing below the total # of visits requested per week to include all Individual Mental Health Services, Collateral Mental Health Services, Group Mental Health Services, or Other Mental Health Services covered under Specialty Mental Health Services.

Request: Specialty Mental Health Services _____ sessions per week.

Start date of this authorization: _____/___/_____ (MM/DD/YYYY) End date of this authorization: _____/___/_____ (MM/DD/YYYY)

Ancillary Assignment Open Date:____/____/_____

Community services/self help do not require authorization but must be coordinated comprehensively with all mental health and psychosocial rehab services.

Community services/self help (please list) _____

ADULT/OLDER ADULT Ancillary Service Necessity Criteria: **CHECK ALL THAT APPLY and complete description.**

☐ The client is unable to receive these services while attending the Day Rehabilitation program due to client's specific clinical needs or family/caregiver needs. (Describe needs) _____

☐ Client transition issues make these services necessary for a time limited interval. (Describe why transition services are needed and length of interval) _____

☐ These concurrent services are essential to coordination of care. (Describe why services are essential for coordination) _____

CHILD and YOUTH Ancillary Service Necessity Criteria: **CHECK ALL THAT APPLY and complete description.**

☐ Requested service(s) is not available through the day program. (Describe why service is not available through day program) _____

☐ Continuity or transition issues make these services necessary for a time limited interval. (Describe why transition services are needed and time interval) _____

☐ These concurrent services are essential to coordination of care. (Describe why services are essential for coordination) _____

CURRENT FUNCTIONING (CFARS Rating) :

1	2	3	4	5	6	7	8	9
No problem	**Less than Slight**	**Slight Problem**	**Slight to Moderate**	**Moderate Problem**	**Moderate to Severe**	**Severe Problem**	**Severe to Extreme**	**Extreme Problem**

Depression			**Anxiety**		
☐Depressed Mood	☐Happy	☐Sleep Problems	☐Anxious/Tense	☐Calm	☐Guilt
☐Sad	☐Hopeless	☐Lacks Energy / Interest	☐Phobic	☐Worried/ Fearful	☐Anti-Anxiety Meds
☐Irritable	☐Withdrawn	☐Anti-Depression Meds	☐Obsessive	☐Panic	
Hyper activity			**Thought Process**		
☐Manic	☐Inattentive	☐Agitated	☐Illogical	☐Delusional	☐Hallucinations
☐Sleep Deficit	☐Overactive / Hyperactive	☐Mood Swings	☐Paranoid	☐Ruminative	☐Command Hallucinations
☐Pressured Speech	☐Relaxed	☐Impulsivity	☐Derailed Thinking	☐Loose Associations	☐Intact
☐ADHD Meds	☐Anti-Manic Meds		☐Oriented	☐Disoriented	☐Anti-Psych Meds

Cognitive Performance		**Medical / Physical**		
☐Poor Memory	☐Low Self-Awareness	☐Acute Illness	☐Hypochondria	☐Good Health
☐Poor Attention/Concentration	☐Developmental Disability	☐CNS Disorder	☐Chronic Illness	☐Need Med./Dental Care
☐Insightful	☐Concrete Thinking	☐Pregnant	☐Poor Nutrition	☐Enuretic/ Encopretic
☐Impaired Judgment	☐Slow Processing	☐Eating Disorder	☐Seizures	☐Stress-Related Illness
Traumatic Stress		**Substance Use**		
☐Acute	☐Dreams/Nightmares	☐Alcohol	☐Drug(s)	☐Dependence
☐Chronic	☐Detached	☐Abuse	☐Over the Counter Drugs	☐Cravings/Urges
☐Avoidance	☐Repression/Amnesia	☐DUI	☐Abstinent	☐I.V . Drugs
☐Upsetting Memories	☐Hyper Vigilance	☐Recovery	☐Interfere w/Functioning	☐Med. Control

Interpersonal Relationships		**Behavior in "Home" Setting**	
☐Problems w/Friends	☐Diff. Estab./ Maintain	☐Disregards Rules	☐Defies Authority
☐Poor Social Skills	☐Age-Appropriate Group	☐Conflict w/Sibling or Peer	☐Conflict w/Parent or Caregiver
☐Adequate Social Skills	☐Supportive Relationships	☐Conflict w/Relative	☐Respectful
☐Overly Shy		☐Responsible	

ADL Functioning			**Socio-Legal**		
☐Handicapped	☐Not Age Appropriate In:		☐Disregards Rules	☐Offense/Property	☐Offense/Person
☐Permanent Disability	☐Communication	☐Self Care	☐Fire Setting	☐Comm. Control/Reentry	☐Pending Charges
☐No Known Limitations	☐Hygiene	☐Recreation	☐Dishonest	☐Use/Con Other(s)	☐Incompetent to Proceed
	☐Mobility		☐Detention/ Commitment		☐Street Gang Member
Select: ☐ Work ☐School			**Danger to Self**		
☐Absenteeism	☐Poor Performance	☐Regular	☐Suicidal Ideation	☐Current Plan	☐Recent Attempt
☐Dropped Out	☐Learning disabilities	☐Seeking	☐Past Attempt	☐Self-Injury	☐Self-Mutilation
☐Employed	☐Doesn't Read/Write	☐Tardiness	☐"Risk-Taking" Behavior	☐Serious Self-Neglect	☐Inability to Care for Self
☐Defies Authority	☐Not Employed	☐Suspended			
☐Disruptive	☐Terminated/ Expelled	☐Skips Class			

Danger to Others		**Security/ Management Needs**	
☐Violent Temper	☐Threatens Others	☐Home w/o Supervision	☐Suicide Watch
☐Causes Serious Injury	☐Homicidal Ideation	☐Behavioral Contract	☐Locked Unit
☐Use of Weapons	☐Homicidal Threads	☐Protection from Others	☐Seclusion
☐Assaultive	☐Homicide Attempt	☐Home w/Supervision	☐Run/Escape Risk
☐Cruelty to Animals	☐Accused of Sexual Assault	☐Restraint	☐Involuntary Exam/ Commitment
☐Does not appear dangerous to Others	☐Physically Aggressive	☐Time-Out	☐PRN Medications
		☐Monitored House Arrest	☐One-to-One Supervision

Clinician requesting authorization: (print)_____**Phone:**_____ **Date:**_____

Countersignature by Licensed Clinician:_____ **Phone:**_____ **Date:**_____

Created by UBH 01-1-05 Revised 9.01.10

This form should be used to request *continued authorization* of payment for Day Program services	County of San Diego Mental Health Plan ***CONTINUED*** **Day Program Request** RECEIVED:	Fax/Mail to: OptumHealth Public Sectpr, 3111 Camino del Rio North, Suite 500 San Diego, CA 92108 Phone: (800) 798-2254, option 4 Fax: (866) 220-4495

CLIENT INFORMATION ****CONFIDENTIAL****

Client Name: (*First & Last*)	Client Anasazi ID #	Date of Birth

DAY PROGRAM INFORMATION

Legal Entity & Day Program Name: *Please print clearly*

_____Phone:_____ Assignment Open Date _____/_____/_____

Day Program Unit#_____ Subunit# _____

Anticipated Discharge Date _____/____/_____ Current Session Frequency : _____ days a week
mm/dd/yyyy

CONTINUED AUTHORIZATION REQUEST: ☐ Intensive Day Treatment ☐ Day Rehab Frequency : _____ days a week

Begin Date for this Request: ____/____/____ End Date for this Request: ____/____/____
mm/ dd/ yyyy mm/ dd/ yyyy

HISTORY

☐ **Significant Life Events Since Last Review** :

_____

DAY PROGRAM SERVICE NECESSITY CRITERIA **COMPLETE DIAGNOSIS and CHECK ALL THAT APPLY**

DIAGNOSIS ***TIP:*** Use **DSM-IV** Codes; include all Axes**.** **Client must also meet Title 9 Medical Necessity Criteria**

Axis I - Primary _____ **Axis II** -_____ **Axis III** - _____

Secondary _____

Axis IV _____ **Axis V** (*GAF*) Current _____ **Highest in last 12 months**_____

For adult clients only: Day Program Services Medical Necessity #_____ (Please review Day Program Medical Necessity Grid to determine this number)

SERVICE NECESSITY CRITERIA

1) Client exhibits an impairment in functioning due to the above diagnosis as demonstrated by one or more of the following:

A. ☐ Substantial impairment in living arrangement, daily activities, social relationships, and/or age appropriate ADL skills as demonstrated by: (describe)_____

_____

B. ☐ Risk factors such as recurring psychotic symptoms, suicidal or homicidal ideation without evidence of plan, or other violent ideation or behavior as demonstrated by: (describe) _____

_____

C. ☐ Demonstrative history that without day program services there is a substantial risk of recurrence of A. or B. (describe behavior/history supporting risk.)_____

_____

D. ☐ *(For children/youth* Probability that child will not progress developmentally as individually appropriate or will deteriorate developmentally as demonstrated by:_____

2) ☐ Client (and family for children) has been in, or is currently in lower level of care and the client has not demonstrated progress or stabilization (describe progress or lack of progress)_____

_____

3) ☐ Client requires structured Day Program in order to move successfully from higher level of care to lower level of care or to prevent deterioration in functioning and admission to a higher level of care. (describe how is this determined)_____

_____

4) ☐ Present living situation and functioning indicate need for structured day program. Describe living situation & functioning that supports need for Day Program. _____

_____

5) ☐ Current treatment goals have not been met. There is progress toward treatment goals or a reasonable expectation that progress will be made during the next authorization cycle. _____

CLIENT INFORMATION	*******CONFIDENTIAL*******	
Client Name: (*First & Last*)	Client Anasazi ID #:	Date of Birth:

CLIENT AREAS of STRENGTH	**DESCRIBE STRENGTHS IN DETAIL (For children, include family strengths)**
Job, School, Daily Activities	
Relationships, Family, Social Supports	
Social Activities, Interests	

TREATMENT GOALS: List goals directed at improving functioning. **Progress Rating Scale**: **N – New Goal, 1 – Much worse, 2 – Somewhat worse, 3 – No change, 4 – Slight Improvement, 5 – Great improvement, R – Resolved**

Measurable Behavioral Goal:	**As Demonstrated by:**	**Method(s) for Achieving Goal**	**Progress since last report**

Client received psychiatric evaluation? ☐ Yes ☐ No **NAME OF PSYCHIATRIST**:

CURRENT MEDICATIONS	**Current Dose**	**CURRENT MEDICATIONS**	**Current Dose**

REQUIRED ATTACHMENTS

PLEASE SUBMIT THE FOLLOWING DOCUMENT WITH THIS CONTINUING DAY PROGRAM REQUEST:

☐ Specialty Mental Health Services DPR if the client receives ancillary services in addition to Day Program Services.

CURRENT FUNCTIONING (CFARS Rating):

1	2	3	4	5	6	7	8	9
No problem	**Less than Slight**	**Slight Problem**	**Slight to Moderate**	**Moderate Problem**	**Moderate to Severe**	**Severe Problem**	**Severe to Extreme**	**Extreme Problem**

Depression _____			**Anxiety** _____		
☐Depressed Mood	☐Happy	☐Sleep Problems	☐Anxious/Tense	☐Calm	☐Guilt
☐Sad	☐Hopeless	☐Lacks Energy / Interest	☐Phobic	☐Worried/ Fearful	☐Anti-Anxiety Meds
☐Irritable	☐Withdrawn	☐Anti-Depression Meds	☐ Obsessive/Compulsive	☐Panic	
Hyper activity _____			**Thought Process** _____		
☐Manic	☐Inattentive	☐Agitated	☐Illogical	☐Delusional	☐Hallucinations
☐Sleep Deficit	☐Overactive / Hyperactive	☐Mood Swings	☐Paranoid	☐Ruminative	☐Command Hallucination
☐Pressured Speech	☐Relaxed	☐Impulsivity	☐Derailed Thinking	☐Loose Associations	☐Intact
☐ADHD Meds	☐Anti-Manic Meds		☐Oriented	☐Disoriented	☐Anti-Psych Meds
Cognitive Performance _____			**Medical / Physical** _____		
☐Poor Memory	☐Low Self-Awareness		☐Acute Illness	☐Hypochondria	☐Good Health
☐Poor Attention/Concentration	☐Developmental Disability		☐CNS Disorder	☐Chronic Illness	☐Need Med./Dental Care
☐Insightful	☐Concrete Thinking		☐Pregnant	☐Poor Nutrition	☐Enuretic/ Encopretic
☐Impaired Judgment	☐Slow Processing		☐Eating Disorder	☐Seizures	☐Stress-Related Illness
Traumatic Stress _____			**Substance Use** _____		
☐Acute	☐Dreams/Nightmares		☐Alcohol	☐Drug(s)	☐Dependence
☐Chronic	☐Detached		☐Abuse	☐Over Counter Drugs	☐Cravings/Urges
☐Avoidance	☐Repression/Amnesia		☐DUI	☐Abstinent	☐I.V . Drugs
☐Upsetting Memories	☐Hyper Vigilance		☐Recovery	☐Interfere w/Functioning	☐Med. Control
Interpersonal Relationships _____			**Behavior in "Home" Setting** _____		
☐Problems w/Friends	☐Diff. Estab./ Maintain		☐Disregards Rules	☐Defies Authority	
☐Poor Social Skills	☐Age-Appropriate Group		☐Conflict w/Sibling or Peer	☐Conflict w/Parent or Caregiver	
☐Adequate Social Skills	☐Supportive Relationships		☐Conflict w/Relative	☐Respectful	
☐Overly Shy			☐Responsible		
ADL Functioning _____			**Socio-Legal** _____		
☐Handicapped	☐Not Age Appropriate In:		☐Disregards Rules	☐Offense/Property	☐Offense/Person
☐Permanent Disability	☐ Communication	☐Self Care	☐Fire Setting	☐Comm. Control/Reentry	☐Pending Charges
☐No Known Limitations	☐Hygiene	☐Recreation	☐Dishonest	☐Use/Con Other(s)	☐Incompetent to Proceed
	☐Mobility		☐Detention/ Commitment		☐Street Gang Member
Select: ☐ Work ☐School _____			**Danger to Self** _____		
☐Absenteeism	☐Poor Performance	☐Regular	☐Suicidal Ideation	☐Current Plan	☐Recent Attempt
☐Dropped Out	☐Learning disabilities	☐Seeking	☐Past Attempt	☐Self-Injury	☐Self-Mutilation
☐Employed	☐Doesn't Read/Write	☐Tardiness	☐"Risk-Taking" Behavior	☐Serious Self-Neglect	☐Inability to Care for Self
☐Defies Authority	☐Not Employed	☐Suspended			
☐Disruptive	☐Terminated/ Expelled	☐Skips Class			
Danger to Others _____			**Security/ Management Needs** _____		
☐Violent Temper	☐Threatens Others		☐Home w/o Supervision	☐Suicide Watch	
☐Causes Serious Injury	☐Homicidal Ideation		☐Behavioral Contract	☐Locked Unit	
☐Use of Weapons	☐Homicidal Threats		☐Protection from Others	☐Seclusion	
☐Assaultive	☐Homicide Attempt		☐Home w/Supervision	☐Run/Escape Risk	
☐Cruelty to Animals	☐Accused of Sexual Assault		☐Restraint	☐Involuntary Exam/ Commitment	
☐Does not appear dangerous to Others	☐Physically Aggressive		☐Time-Out	☐PRN Medications	
			☐Monitored House Arrest	☐One-to-One Supervision	

Day Program Clinician: (print) _____ Date: _____

Countersignature by Licensed Clinician: _____ Date: _____

For OptumHealth Disposition Only: DOCUMENT AUTHORIZATIONS FOR DAY PROGRAM and ANCILLARY SERVICES

OptumHealth Clinician #:_____ Day Program Authorization Period: Begin Date:_____ End Date:_____

Approved # Days:_____ Frequency (# times/week) _____ Review Date:_____ Circle approved AS on next page(s) Logged ☐

Reduce DP Request:☐ Deny DP Request:☐ Date NOA Sent: _____ Reduce AS Request:☐ Deny AS Request:☐
Date NOA Sent:_____

Date DP Auths Entered:_____ **Date AS Auths Entered:**_____ **D/E Name:**_____ **Logged** ☐

Created by UBH 01-1-05 Revised 9.01.10

UTILIZATION MANAGEMENT REQUEST AND AUTHORIZATION
Outpatient Treatment & Case Management Programs
Children's Programs Only

2012

WHEN: Prior to an outpatient client reaching the end of the initial 13 sessions included individual sessions or up to 18 family or group only included sessions from the date the assignment was opened at the Unit/SubUnit. Subsequently, the Utilization Management (UM) Authorization shall be completed prior to the expiration of the previous UM Authorization.

ON WHOM: All outpatient and case management clients meeting above requirements who are clients receiving individual, group or family therapy. This excludes medication management, CMBR only, unplanned services such as Crisis Intervention (CI), plan development, evaluation of records, report preparation, TBS, psychological testing (for those programs approved to do testing); collateral (contact with significant others such as teachers, PO, CWS, and parent). Paraprofessional rehabilitative services (R-individual, R-group, R-family). Rehabilitative services provided by a clinician are included services.

Clients who are simultaneously enrolled in a Day Program obtain authorization through the Day Provider (until the client leaves the day treatment program).

COMPLETED BY: Request form may be completed by:

Physician,
Licensed/Waivered Psychologist,
Licensed/Registered/Waivered Social Worker,
Licensed/Registered/Waivered Marriage Family Therapist, or
Registered Nurse.
Trainee,
Mental Health Rehab specialist,
Rehab staff, or
Paraprofessional
The program sets co-signature requirements.

The UM Authorization shall be approved by a licensed or waivered clinician. The clinician member authorizing the sessions cannot be the same as the staff who submitted the UM form.

MODE OF COMPLETION: Legibly handwritten, typed, or word-processed on Utilization Management Authorization form.

REQUIRED ELEMENTS: Staff requesting services outline the date of initial admission in the program, type of services offered by program, current planned session frequency per month, number of additional sessions requested and any additional comments. A five-axis diagnosis shall be completed. Note if family is involved in treatment, and if youth or family are requesting continuation of service. Check off any concurrent interventions treatment client is involved with, and any prior hospitalizations.

Staff requesting services complete the Current Client Functioning (CFARS) section. Complete rationale for additional service/s need.

Staff requesting services beyond the initial 13 sessions must summarize the Eligibility Criteria for the appropriate request (post initial 13 sessions or post 26 sessions)

Staff requesting services identify all the proposed treatment modalities with the planned frequency. The expected outcome and prognosis follows. The requesting staff then outlines the actual requested number of treatment sessions to continue providing services after the initial 13 session mark or the previous UM authorization (for those requests past the 26 sessions).

The requesting staff attaches Client Plan (with or without the client's and guardian's signature) proposals/changes/additions, and then prints, signs, and dates the request. (NOTE: the Client Plan does need to be signed in order to continue beyond the initial 13 sessions). Each program determines co-signature requirements for the authorization request form. **CLIENT PLAN PROPOSALS/CHANGES/ADDITIONS MUST BE SUBMITTED WITH THE UM REQUEST FORM.** Once the UM request is approved the proposed changes/additions must be incorporated in to the Client Plan using either the review function or by rewriting a new Client Plan (revise is not acceptable for this process) within the EHR.

The UM representative identifies the approved number of sessions post the 13 session mark or the previous UM authorization up to an additional 13 sessions. The UM representative selects the appropriate box indicating if the request was approved, reduced, or denied. UM representative may outline any comments or suggestions to the requesting staff. Retroactive authorization is not acceptable (the program must contact the COTR when a client has no UM in place to cover claims). The UM representative completing the review prints name, signs, and dates the form. The UM approval must be completed by a licensed clinician only.

BILLING:

Utilization Management is a non-billable activity. Therefore, there is no billing for preparation of the UM form or for the UM review time spent on the case. UM is an administrative function.

UTILIZATION MANAGEMENT AUTHORIZATION
Outpatient Treatment

Review Date: _____

Date of Program Admission: _____

Current Services: ☐MHS ☐MHS-R ☐CM ☐Meds

Current Planned Session Frequency:

☐ _____ session/s per month

☐ Comments:

Is Family Involved with Treatment? Y N (*If no please explain):*_____

_____

DSM IV – TR **Axis I** – Primary: _____ Code: _____

Secondary: _____ Code:_____

Other: _____ Code:_____

Axis II - _____ Code:_____

Axis III - _____ Code:_____

Axis IV - ☐ Primary Support Group ☐ Social Environment ☐Educational ☐Occupational ☐Housing ☐Economic ☐Access to Health Care ☐Interaction with the Legal System ☐Other psychosocial and Environmental Problems

Axis V - (*GAF*) **Current:** _____ **Highest in last 12 months:** _____

Does youth and/or family request continuation of service? Y N (*Comments*): _____

Concurrent Interventions: (*Please Check off all that apply*): ☐TBS ☐Day Treatment Intensive ☐Day Treatment Rehabilitation ☐Chemical Dependency ☐Rehabilitation ☐Other Outpatient (*Please Specify*): _____

Hospitalizations: Y N (*If yes please specify how long ago)*: ☐past month ☐past 3 months ☐past 6 months ☐past year ☐more than one year

CURRENT CLIENT FUNCTIONING (CFARS Rating):

1	2	3	4	5	6	7	8	9
No problem	**Less than Slight**	**Slight Problem**	**Slight to Moderate**	**Moderate Problem**	**Moderate to Severe**	**Severe Problem**	**Severe to Extreme**	**Extreme Problem**

Depression ____ **Treatment Focus Y N**			**Anxiety** ____ **Treatment Focus Y N**		
☐Depressed Mood	☐Happy	☐Sleep Problems	☐Anxious/Tense	☐Calm	☐Guilt
☐Sad	☐Hopeless	☐Lacks Energy / Interest	☐Phobic	☐Worried/ Fearful	☐Anti-Anxiety Meds
☐Irritable	☐Withdrawn	☐Anti-Depression Meds	☐Obsessive/Compulsive	☐Panic	

Hyper activity ____ **Treatment Focus Y N**			**Thought Process** ____ **Treatment Focus Y N**		
☐Manic	☐Inattentive	☐Agitated	☐Illogical	☐Delusional	☐Hallucinations
☐Sleep Deficit	☐Overactive / Hyperactive	☐Mood Swings	☐Paranoid	☐Ruminative	☐Command Hallucination
☐Pressured Speech	☐Relaxed	☐Impulsivity	☐Derailed Thinking	☐Loose Associations	☐Intact
☐ADHD Meds	☐Anti-Manic Meds		☐Oriented	☐Disoriented	☐Anti-Psych Meds

Cognitive Performance ____ **Treatment Focus Y N**		**Medical / Physical** ____ **Treatment Focus Y N**		
☐Poor Memory	☐Low Self-Awareness	☐Acute Illness	☐Hypochondria	☐Good Health
☐Poor Attention/Concentration	☐Developmental Disability	☐CNS Disorder	☐Chronic Illness	☐Need Med./Dental Care
☐Insightful	☐Concrete Thinking	☐Pregnant	☐Poor Nutrition	☐Enuretic/ Encopretic
☐Impaired Judgment	☐Slow Processing	☐Eating Disorder	☐Seizures	☐Stress-Related Illness

Traumatic Stress ____ **Treatment Focus Y N**		**Substance Use** ____ **Treatment Focus Y N**		
☐Acute	☐Dreams/Nightmares	☐Alcohol	☐Drug(s)	☐Dependence
☐Chronic	☐Detached	☐Abuse	☐Over Counter Drugs	☐Cravings/Urges
☐Avoidance	☐Repression/Amnesia	☐DUI	☐Abstinent	☐I.V . Drugs
☐Upsetting Memories	☐Hyper Vigilance	☐Recovery	☐Interfere w/Functioning	☐Med. Control

Interpersonal Relationships ____ **Treatment Focus Y N**		**Behavior in "Home" Setting** ____ **Treatment Focus Y N**	
☐Problems w/Friends	☐Diff. Estab./ Maintain	☐Disregards Rules	☐Defies Authority
☐Poor Social Skills	☐Age-Appropriate Group	☐Conflict w/Sibling or Peer	☐Conflict w/Parent or Caregiver
☐Adequate Social Skills	☐Supportive Relationships	☐Conflict w/Relative	☐Respectful
☐Overly Shy		☐Responsible	

ADL Functioning ____ **Treatment Focus Y N**			**Socio-Legal** ____ **Treatment Focus Y N**		
☐Handicapped	☐Not Age Appropriate In:		☐Disregards Rules	☐Offense/Property	☐Offense/Person
☐Permanent Disability	☐Communication	☐Self Care	☐Fire Setting	☐Comm. Control/Reentry	☐Pending Charges
☐No Known Limitations	☐Hygiene	☐Recreation	☐Dishonest	☐Use/Con Other(s)	☐Incompetent to Proceed
	☐Mobility		☐Detention/ Commitment		☐Street Gang Member

Select: ☐ Work ☐School ____ **Treatment Focus Y N**			**Danger to Self** ____ **Treatment Focus Y N**		
☐Absenteeism	☐Poor Performance	☐Regular	☐Suicidal Ideation	☐Current Plan	☐Recent Attempt
☐Dropped Out	☐Learning disabilities	☐Seeking	☐Past Attempt	☐Self-Injury	☐Self-Mutilation
☐Employed	☐Doesn't Read/Write	☐Tardiness	☐"Risk-Taking" Behavior	☐Serious Self-Neglect	☐Inability to Care for Self
☐Defies Authority	☐Not Employed	☐Suspended			
☐Disruptive	☐Terminated/ Expelled	☐Skips Class			

Danger to Others ____ **Treatment Focus Y N**		**Security/ Management Needs** ____ **Treatment Focus Y N**	
☐Violent Temper	☐Threatens Others	☐Home w/o Supervision	☐Suicide Watch
☐Causes Serious Injury	☐Homicidal Ideation	☐Behavioral Contract	☐Locked Unit
☐Use of Weapons	☐Homicidal Threats	☐Protection from Others	☐Seclusion
☐Assaultive	☐Homicide Attempt	☐Home w/Supervision	☐Run/Escape Risk
☐Cruelty to Animals	☐Accused of Sexual Assault	☐Restraint	☐Involuntary Exam/ Commitment
☐Does not appear dangerous to Others	☐Physically Aggressive	☐Time-Out	☐PRN Medications
		☐Monitored House Arrest	☐One-to-One Supervision

RATIONEL FOR ADDITIONAL SERVICE NEED

ELIGIBILITY CRITERIA – POST INITIAL 13 SESSIONS

- ☐ **Client continues to meet Medical Necessity and demonstrates benefit from services**
- ☐ **Consistent participation in services**
- ☐ CFARS-Impairment Rating guideline of 5

☐ **Client meets the criteria for SED based upon the following:**

As a result of a mental disorder the child has **substantial** and **persistent** impairment in at least two of the following areas (check):

- ☐ Self-care and self regulation
- ☐ Family relationships
- ☐ Ability to function in the community
- ☐ School functioning

AND One of the following occurs:

- ☐ Child at risk for removal from home due to a mental disorder
- ☐ Child has been removed from home due to a mental disorder
- ☐ Mental disorder/impairment is severe and has been present for six months, or is highly likely to continue for more than one year without treatment.

OR The child displays:

- ☐ acute psychotic features,
- ☐ imminent risk for suicide
- ☐ imminent risk of violence to others due to a mental disorder

ELIGIBILITY CRITERIA – POST 26 SESSIONS

☐ **Client has met the above criteria as indicated AND**

Meets a minimum of one continuing current Risk Factor related to child's primary diagnosis:

- ☐ Child has been a danger to self or other in the last two weeks
- ☐ Child experienced severe physical or sexual abuse or has been exposed to extreme violent behaviors in the home in the last two weeks
- ☐ Child's behaviors are so substantial and persistent that current living situation is in jeopardy
- ☐ Child exhibited bizarre behaviors in the last two weeks
- ☐ Child has experienced trauma within the last two weeks

Proposed Treatment Modalities	Planned Frequency	Expected Outcome and Prognosis	REQUESTED NUMBER OF TREATMENT SESSIONS
☐ MHS – Family	_____ session(s) per month	☐ Return to full functioning	
☐ MHS – Group	_____ session(s) per month	☐ Expect improvement, anticipate less than full functioning	
☐ MHS – Individual	_____ session(s) per month	☐ Relieve acute symptoms, return to baseline functioning	
☐ MHS - Collateral	_____ session(s) per month	☐ Maintain current status/prevent deterioration	
☐ Case Management/Brokerage	_____ session(s) per month		
☐ MHS – Rehab	_____ session(s) per month		
☐ Medication Support	_____ session(s) per month		

Requesting Staff's Name, Credential, Signature: _____ **Date:** _____

Co- Signature: _____ **Date:** _____

Approved # of Sessions: _____ Comments: _____

☐ Request Approved ☐ Request Reduced ☐ Request Denied

☐ Retroactive Authorization (must notify COTR by email) _____

UM Clinician's Name: _____ Signature/Credentials: _____ Date: _____

Committee Members Names and Credentials: _____

_____

MENTAL HEALTH SERVICES

2012

PROGRESS NOTES

NOTE: Training for the Client Plans and Progress Notes in the EHR began in October 2011. Training will continue throughout the calendar year 2012. Programs not yet trained to use the EHR to document Client Plans and Progress Notes will continue to use paper during the transition and will be held to the same documentation timelines and standards as outlined in the following descriptions unless noted otherwise.

PROGRESS NOTES

2012

WHEN:	As needed to document client care at every service contact where a progress notes entry is required.
ON WHOM:	All clients with open cases receiving services.
COMPLETED BY:	Staff delivering services within scope of practice. Co-signatures must be completed within timelines. **Note:** When more than one staff member provides services, one staff member may write the progress note for all staff; but the unique role/function/contribution of each staff member participating must be documented.
MODE OF COMPLETION:	Data must be entered into the Electronic Health Record.
REQUIRED ELEMENTS:	Content of each progress note must support the service claimed. When using a template all prompts must be addressed.
BILLING:	After rendering a service, a progress note is to be completed. Service entry shall be completed as a part of the progress noting process. Completion and final approval of the service and the progress note by the staff is a certification that the documented services were provided personally and that the services were medically necessary.
NOTE:	Every progress note within the EHR must be completed and final approved in a timely manner. When it is not completed and final approved (red locked), the note is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Progress notes are not viewed as complete until the assessment is final approved (red locked).

PROGRESS NOTE CORRECTIONS IN ANASAZI

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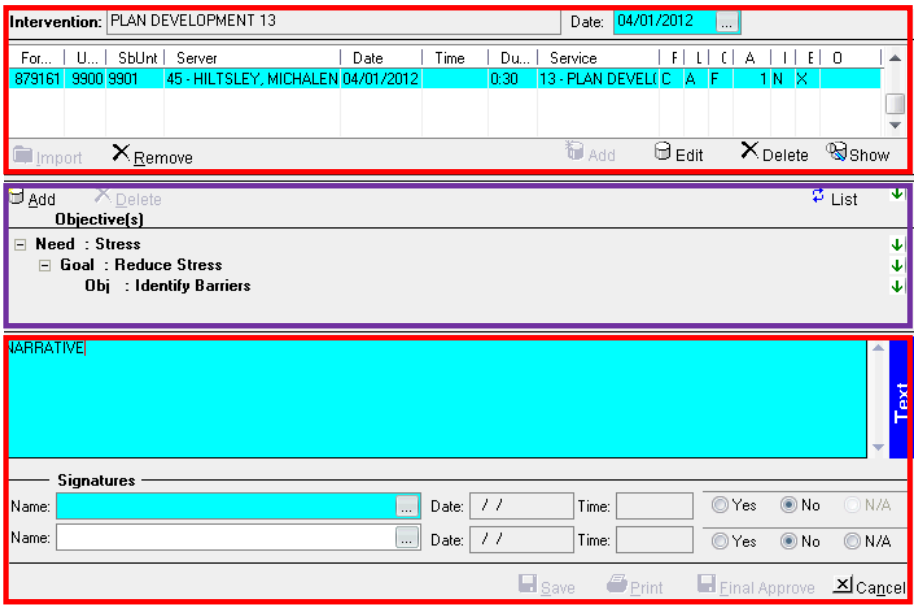
Introduction

Individual Progress Notes within Anasazi have three distinct portions which connect the narrative of the note with a service as well as Goal/s and Objectives. Due to the connection between different portions of the product making corrections to any portion of a note can be different depending on the status of each of these three areas.



The top portion is for service entry. Once a staff has been trained to use Progress Notes, services will be entered through the progress note and will no longer be entered through Individual Service Entry. Once a service is entered in this portion of the progress note it will generate a form number and the service will be ready to claim. The service will claim even if the progress note is not final approved – to prevent disallowances please make sure that all progress notes are final approved in a timely manner. Claiming a service without a final approved note to support the claim will result in a disallowance.

The middle portion is for connecting the service provided and the progress note – what is in the Client Plan. When a planned service (an intervention entered on the Client Plan) is selected the system will automatically pull the linked Goal and Objective for the planned service in to the middle section. When an unplanned service (an intervention not documented on the Client Plan) is selected the system will prompt the staff to select the appropriate Goal and Objective to tie the note to the Client Plan (when one is present). This supports the clinical thread of treatment for the client by tying the documented service to medical necessity and the Client Plan.

The bottom portion is for documenting the narrative that supports the service/intervention provided. The content of the narrative must demonstrate medical necessity and be tied back to the Client Plan and must support the claimed service. The progress note is not considered complete unless all necessary signatures are captured and the note is final approved within timelines. Remember, if the date of documentation and/or date of final approval of the note is past 14 calendar days from the date of service, the service becomes non-billable and must be coded as such.

As a result of the different portions of the product being linked within a single progress note, the instructions for making corrections to a note required additional testing to develop a comprehensive set of directions. In the following sections specific scenarios were reviewed and specific steps are outlined. Please make sure all staff who touch services or progress notes has a copy of this packet for reference.

NOTE: This packet focuses on corrections to Individual Progress Notes. Information related to corrections for Group Progress Notes will be released at a later date. Multi-Service Progress Notes are not to be used in Anasazi – any errors related to these notes must be communicated to the Optum Help Desk immediately for correction.

Progress Note Basics

When can a progress note be deleted?

- A progress note may be deleted only before it is final approved. Once the note is final approved it may not be deleted and voiding the note is the only option. Voided progress notes will always remain in the system and will show as "Voided". If you do or do not want to view voided progress notes, please review your filter settings and change accordingly.

What can I change on a progress note and when?

- When the intervention is selected from the Client Plan as a "Planned" service, it may not be changed once it is pulled in to the service entry portion (the top) – it will show as gray. If you selected the incorrect intervention from the Client Plan, cancel the note and begin again selecting the correct intervention.
- When the intervention is selected as an "Unplanned" service (not a part of the Client Plan), it may be edited once it is pulled in to the service entry portion. If you have selected the incorrect intervention as an "Unplanned" intervention it may be edited until the service is processed for claims. Once the service has been processed for claims, if you attempt to edit it you will receive an error message preventing the action.
- The client assignment, service, travel and documentation time, as well as the service indicators, are entered at the time of building the service entry portion – if you make an error in selecting the client assignment, time, and service indicators the system will allow you to make the correction until the time that the service is processed for claim.
- The date of service cannot be changed once it is selected in the progress note and pulled in to the service entry portion. Double check the date of service before you save the service entry portion.

What can I do to prevent the need to void a progress note?

- Double check the client name – make sure the note is written in the correct client chart.
- Double check the intervention at the time you pull it in to a progress note – once the intervention is selected from the Client Plan, it may not be edited and you must start over. Do not save the service until you have verified the correct intervention/service code.
- Double check the server, service indicators, and assignment. Do not save the service until you have verified the correct server, service indicators and assignment.
- Double check the content of the progress note – make sure it supports the intervention and service entry. Do not save or final approve the note until you have verified all the service entry information and the content of the note. Only final approve when you are certain the note is complete.

What needs to be checked before I request a progress note be voided?

- Check to see if the note is final approved. If it is not final approved it may be deleted. If it is final approved a void may be necessary.
- Check to see if the service has been processed for claims. If the service is processed it may not be edited. If it has not yet been processed some fields may be edited which are completed by the staff who completed the note.
- Check to see if the packet provides instructions on making any corrections prior to requesting the void.
- Submit void requests to the Optum Help Desk with the completed request form – you must complete all fields in order for the void to be processed correctly and promptly.
- If you have questions about any of the instructions or the void request process, contact the Optum Help Desk for guidance.

The following pages will outline specific scenarios and will direct you to the correct action steps. Each of the action steps are outlined step by step in the Appendix and are meant to walk you through the process. If at any time you cannot move forward with the included instructions, please contact the Optum Help Desk for assistance.

Wrong date of service:
If the wrong date of service is selected and pulled in to the service entry portion of the progress note and the note is

- Not final approved – you must delete the progress note and the service (Appendix #1).
- Final approved but the service is not yet claimed - you must void the progress note and delete the service(Appendix #5)
- Final approved and the service is claimed – you must write an Informational Note (Appendix #8).

Wrong Client:
If the progress note was for the wrong client and the note is

- Not final approved – you must delete the progress note and the service (Appendix #1).
- Final approved but the service is not yet claimed – you must void the progress note and delete the service (Appendix #5)
- Final approved and the service is claimed – (when the narrative of the note is written for the wrong client but the service entry is for the correct client) you must void the progress note but keep the service (Appendix #7)

Wrong or Insufficient Information in the Note Narrative:
If the content of the note does not support the intervention or if the wrong client name is entered within the narrative and the note is

- Not final approved – you must delete the progress note and the service (Appendix #1).
- Final approved but the service is not yet claimed – you must void the progress note but keep the service (Appendix #3)
- Final approved and the service is claimed –
    - When service is clinically appropriate – you must void the progress note but keep the service (Appendix #3)
    - When the service is not clinically appropriate – you must void the progress note and void the service (Appendix #7)

Duplicate Progress Note and Service:
If a second progress note was written for the same client for the same service and the note is

- Not final approved – you must delete the progress note and the service (Appendix #1)
- Final approved but the service is yet not claimed – you must void the progress note and delete the service (Appendix #5)
- Final approved and the service is claimed – you must void the progress note and void the service (Appendix #7)

Wrong service indicators or wrong server/s:

- Not final approved – you must delete the progress note and the service (Appendix #1)
- Final approved but the service is not yet claimed – you must edit the service (Appendix #2)
- Final approved and claimed –
    - Wrong service indicator – you must write an Informational Note (Appendix #8)
    - Wrong server – program will hold until further instruction.

Wrong planned service

If the incorrect "Planned" service is selected from the Client Plan, (this includes changing the service code from billable to non-billable) and the note is

- Not final approved – you must delete the progress note and the service (Appendix #1)
- Final approved but the service is not yet claimed – you must void the progress note and delete the service (Appendix #5)
- Final approved and the service is claimed –
    - When the mode and service function code are the same – you must write an Informational Note (Appendix #8)
    - When the mode and service function code are different – program will hold until further instruction

Documented service did not occur:

When the documented service on the progress note did not occur and the note is

- Not final approved – you must delete the progress note and the service (Appendix #1)
- Final approved but the service is not yet claimed – you must void the progress note and delete the service (Appendix #5)
- Final approved and the service is claimed – you must void the progress note and void the service (Appendix #7)

Wrong unplanned service

If the incorrect "Unplanned" service is selected, (this includes changing the service code from billable to non-billable) and the note is

- Not final approved – you must edit the service (Appendix #2)
- Final approved but the service is not yet claimed – you must edit the service (Appendix #2)
- Final approved and the service is claimed –
    - When the mode and service function code are the same – you must write an Informational Note (Appendix #8)
    - When the mode and service function code are different – program will hold until further instruction

No Active Client plan
If a service is documented and not covered by an active Client Plan (when a Plan is required) and the note is

- Not final approved – you must edit the service to a non-billable service code (Appendix #2)
- Final approved but the service is not yet claimed – you must delete the service but keep the progress note (the service entry must reflect the non-billable service code) (Appendix #4)
- Final approved and the service is claimed – you must void the service but keep the progress note (the service entry must reflect the non-billable service code) (Appendix #6)

Time Claimed Greater (or wrong) than Time Documented
If the amount of time entered on the service entry portion is greater than (or wrong) the time documented within the content of the narrative and the note is

- Not final approved – you must edit the service (Appendix #2)
- Final approved but the service is not yet claimed – you must edit the service (Appendix #2)
- Final approved and the service is claimed – program will hold until further instruction

Lockouts and Non-Billable Services
If a service was provided during a lockout or was a non-billable service (i.e. transportation, academic, vocational, recreation or socialization) and the note is

- Not final approved – you must edit the service (Appendix #2)
- Final approved but the service is not yet claimed – you must delete the service but keep the progress not (Appendix #4)
- Final approved and claimed – you must void the service but keep the progress note (Appendix #6)

Clerical Services/Payee Related Service
If the service was a clerical service and/or a payee related service and the note is

- Not final approved – you must delete the progress note and the service (Appendix #1)
- Final approved but the service is not yet claimed – you must void the progress note and delete the service (Appendix #5)
- Final approved and claimed – you must void the progress note and void the service (Appendix #7)

Wrong Unit/SubUnit
If the wrong Unit and/or SubUnit are selected in the service entry portion and the note is

- Not final approved – you must edit the service (Appendix #2)
- Final approved but the service is not yet claimed – you must edit the service (Appendix #2)
- Final approved and claimed – you must write an Informational Note (Appendix #8)

No Show Entered as a Service
If a No Show is documented within the narrative without the use of the "5 – No Show" service indicator and the note is

- Not final approved – you must edit the service indicator and select "No Show" (Appendix #2)
- Final approved but the service is not yet claimed – you must edit service indicator and select "No Show" (Appendix #2)
- Final approved and the service is claimed – you must void the service but keep the progress note (Appendix #6)

Documentation Past 14 Days
If the documentation date of the progress note is more than 14 calendar days from the date of service and the note is

- Not final approved – you must edit the service and enter in the appropriate non-billable service code (Appendix #2)
- Final approved but the service is not yet claimed and
    - It is a "Planned" service – you must void the progress note and delete the service (Appendix #5) (Note must be re-entered to reflect the non-billable service code)
    - It is an "Unplanned" service – you must edit the service (Appendix #2)
- Final approved and the service is claimed and
    - It is a "Planned" service –
        - When the mode and service function code are the same – you must write an Informational Note (Appendix #8)
        - When the mode and service function code are different – program will hold until further instruction
    - It is an "Unplanned" service -
        - When the mode and service function code are the same – you must write an Informational Note (Appendix #8)
        - When the mode and service function code are different – program will hold until further instruction

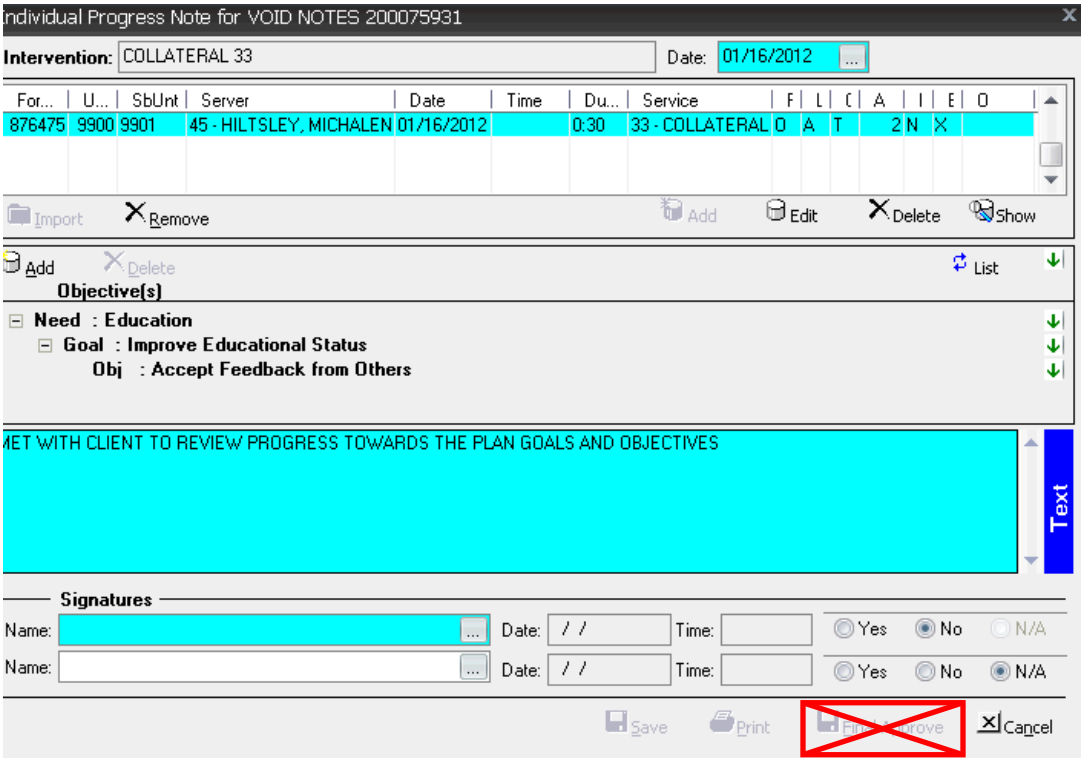
Multiple Scenarios

If a progress note contains more than one of the above factors and the note is

- Not final approved – you must edit the service entry and the narrative (Appendix #2)
- Final approved (the service may or may not yet be claimed – you must contact the Optum Help Desk for assistance

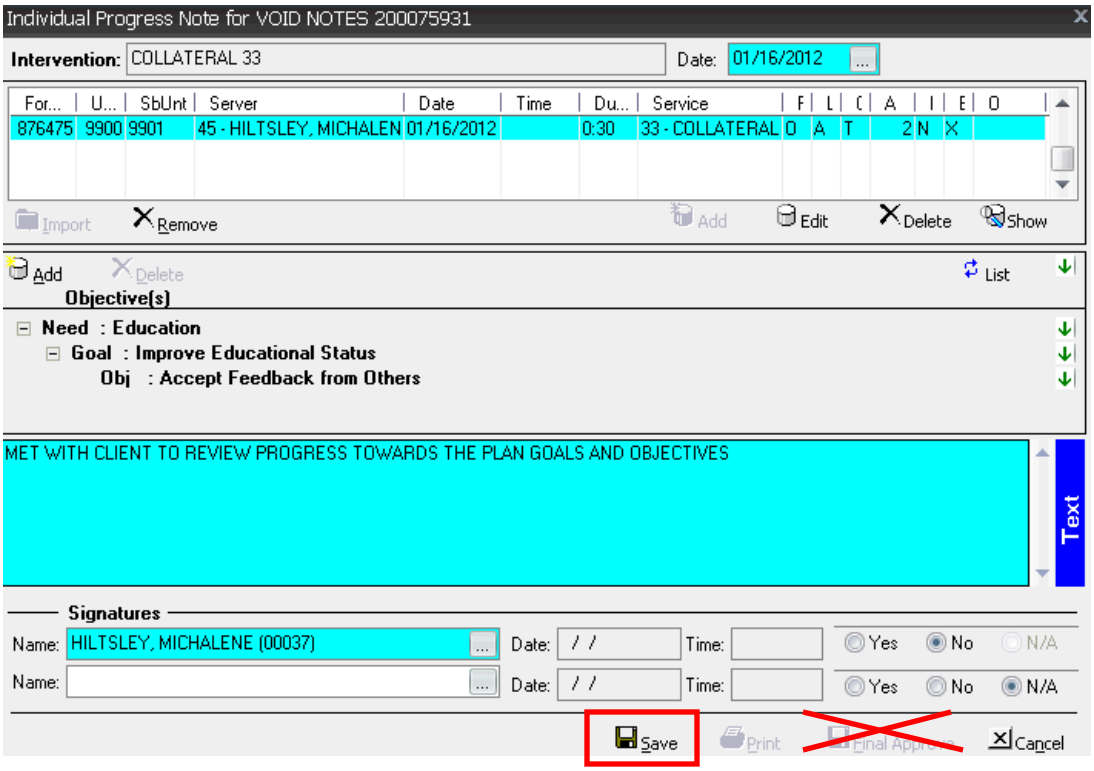
Delete the progress note and the service

Note is **not** final approved AND service is not claimed
(Void is only possible when the progress note is final approved)

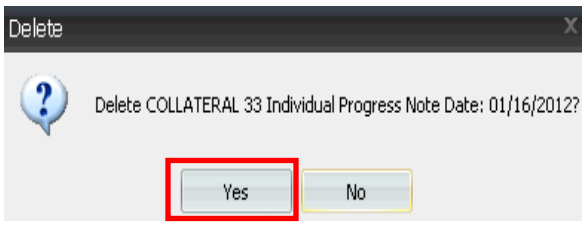


When the note is not yet final approved and an error is identified, there are two ways to delete the note:

1) "Save" the progress note (do not final approve)

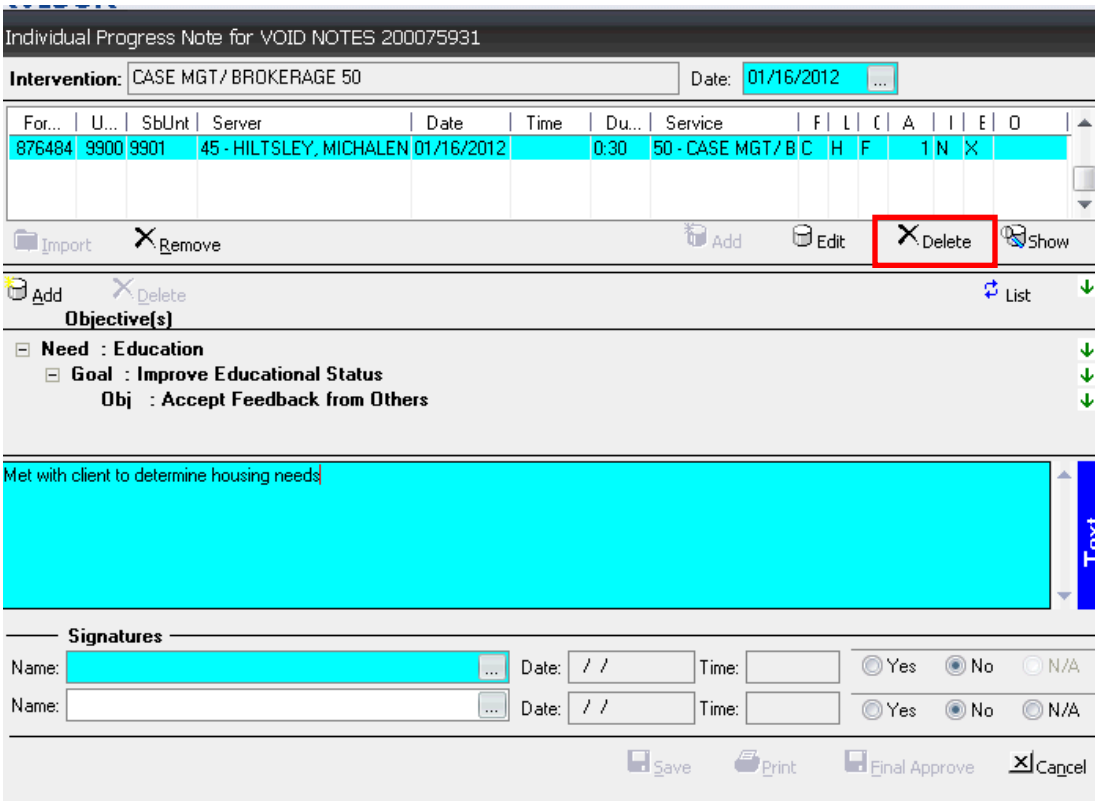


a) Locate the note in the Progress Notes panel, highlight the note and right click on the mouse for the drop down menu. Select “Delete”.

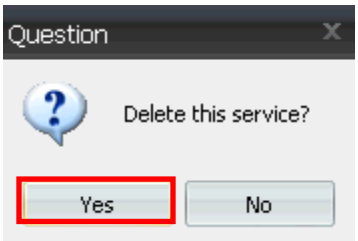


b) Confirm that this is the correct note to delete by selecting “Yes”
c) The deleted note will no longer show in the progress notes panel.

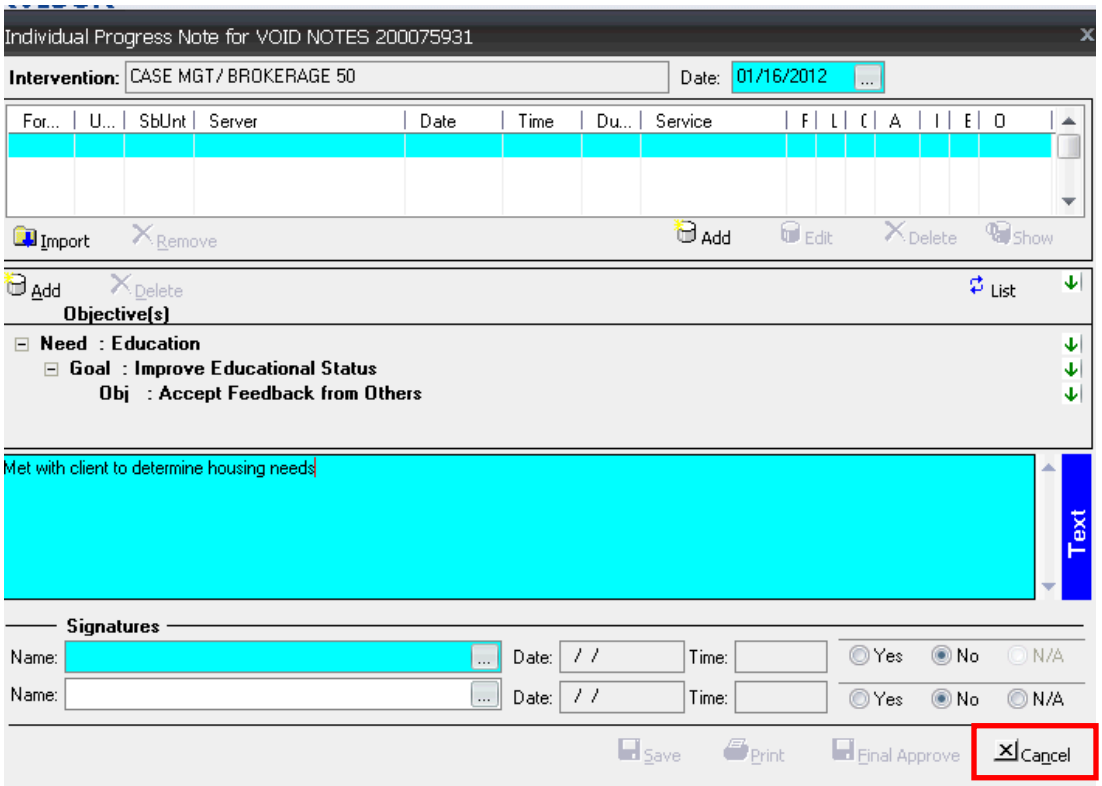
2) Delete the service and cancel the note



a) Select “Delete” for the service entry



b) Verify that you want to delete the service and select “Yes”



c) The last step is to “Cancel” the note.
d) The note will not appear in the progress notes panel.

Edit of a service

Note may or may not be final approved AND service is not claimed

Individual Progress Note for VOID NOTES 200075931

Intervention: CASE MGT/ BROKERAGE 50 Date: 02/06/2012

For...	U...	SbUnt	Server	Date	Time	Du...	Service	F	L	C	A	I	E	O
876488	9900	9901	45 - HILTSLEY, MICHALEN	02/06/2012		0:35	50 - CASE MGT/ B	C	H	F	1	N	X	

Import Remove Add Edit Delete Show

Add Delete List

Objective(s)

Need : Education
Goal : Improve Educational Status
Obj : Accept Feedback from Others

Met with the client to review resources for housing. Client has been evicted and the lack of housing options is negatively impacting his symptoms of anxiety and depression. Client has needed significant support to follow through with the resources to locate immediate housing. Will connect with psychiatrist and clinician regarding symptoms and increased needs during this transition and the need to update the client plan to address this change in needs.

Signatures

Name: HILTSLEY, MICHALENE (00037) Date: 05/14/2012 Time: 3:59 PM Yes No N/A

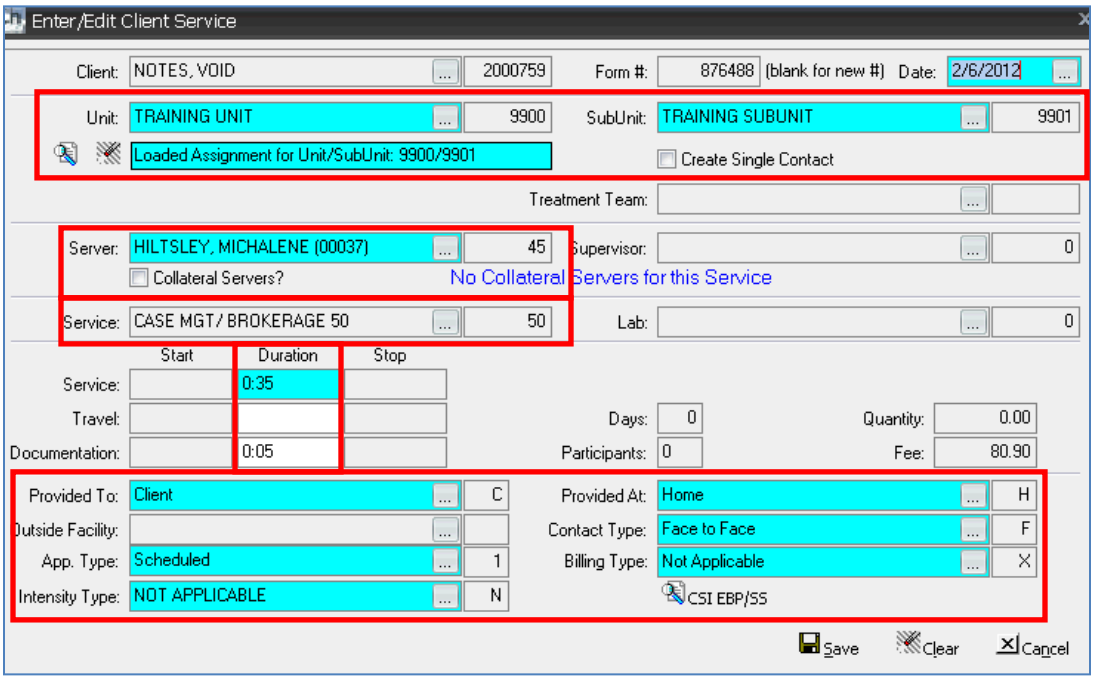
Name: Date: / / Time: Yes No N/A

Print Ok

NOTE: when a progress note is not final approved you may delete the service, delete the note, and/or edit any portions of the service entry as appropriate.

If the progress note is Final Approved, but the service has not yet been claimed, the following items within the service entry portion of the progress note may be edited:

a. Unit and SubUnit
b. Assignment
c. Server
d. Unplanned service code/intervention (in this example you see a planned service code/intervention which cannot be edited – it will be grayed out)
e. Time (service, travel and documentation)
f. Service indicators



Make the corrections to any of the above items and select "Save". This will update the information for the service to claim correctly.

Void progress note but keep service

Note is final approved AND service is not claimed

Individual Progress Note for VOID NOTES 200075931

Intervention: PLAN DEVELOPMENT 13 Date: 01/10/2012

For...	U...	SbUnt	Server	Date	Time	Du...	Service	F	L	C	A	I	E	O
876428	9900	9901	45 - HILTSLEY, MICHALEN	01/10/2012		1:00	13 - PLAN DEVEL(	C	A	F	1	N	X	

Import Remove Add Edit Delete Show

Add Delete List

Objective(s)

Need : Education
Goal : Improve Educational Status
Obj : Accept Feedback from Others

INTERIM CLIENT PLAN NOTE

PRESENTING PROBLEM/S:

MEDICATION/S:

Signatures

Name: HILTSLEY, MICHALENE (00037) Date: 05/08/2012 Time: 2:30 PM Yes No N/A

Name: Date: / / Time: Yes No N/A

Print Ok

Program admin/data entry staff enters a service with the same service date using service code 999. This is completed through Individual Service Entry (and not through a progress note).

Adding Individual Service

Form #	Client	Unit	SubUnit	Server	Service	Date	Start Time	Duration
876449	200075931 - NOTES, VOID	9900 - TRAI	9901 - TRAIN	45 - HILTSLEY, M	999 - VOID PRC	01/10/2012		

Form #: Date: 01/10/2012 Client: NOTES, VOID 200075931

Unit: TRAINING UNIT 9900 SubUnit: TRAINING SUBUNIT 9901

Loaded Assignment for Unit/SubUnit: 9900/9901 Single Contact

Treatment Team: Server: HILTSLEY, MICHALENE (00037) 45

Supervisor: Collateral Servers

Service: VOID PROGRESS NOTE 999 Lab:

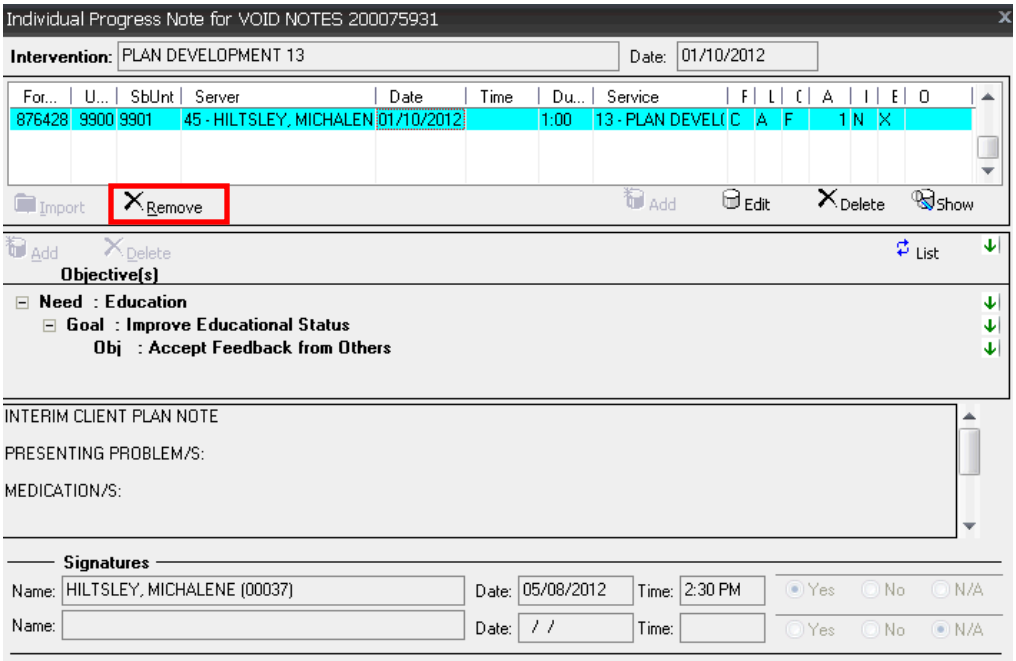
S. Time: Days/Part: Person Place O. Fac

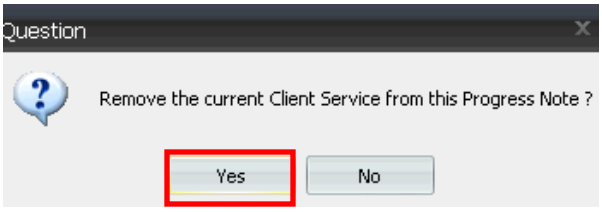
T. Time: Quantity: C. Type A. Type B. Type

D. Time: Fee: I. Type CSI EBP/SS

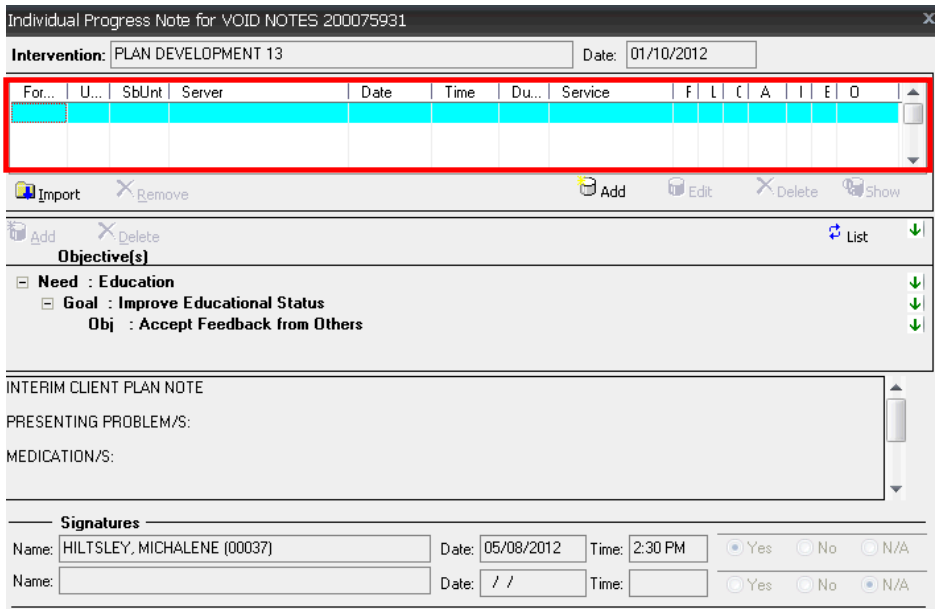
Payment Save Clear Delete Exit

Program clinician **removes** the incorrect service from the progress note.

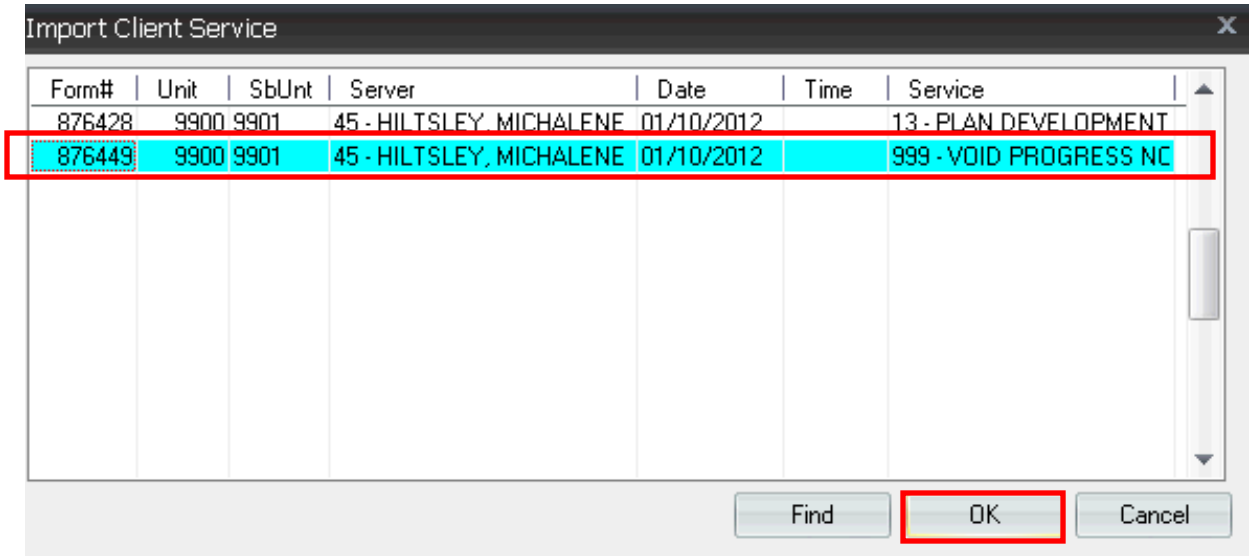




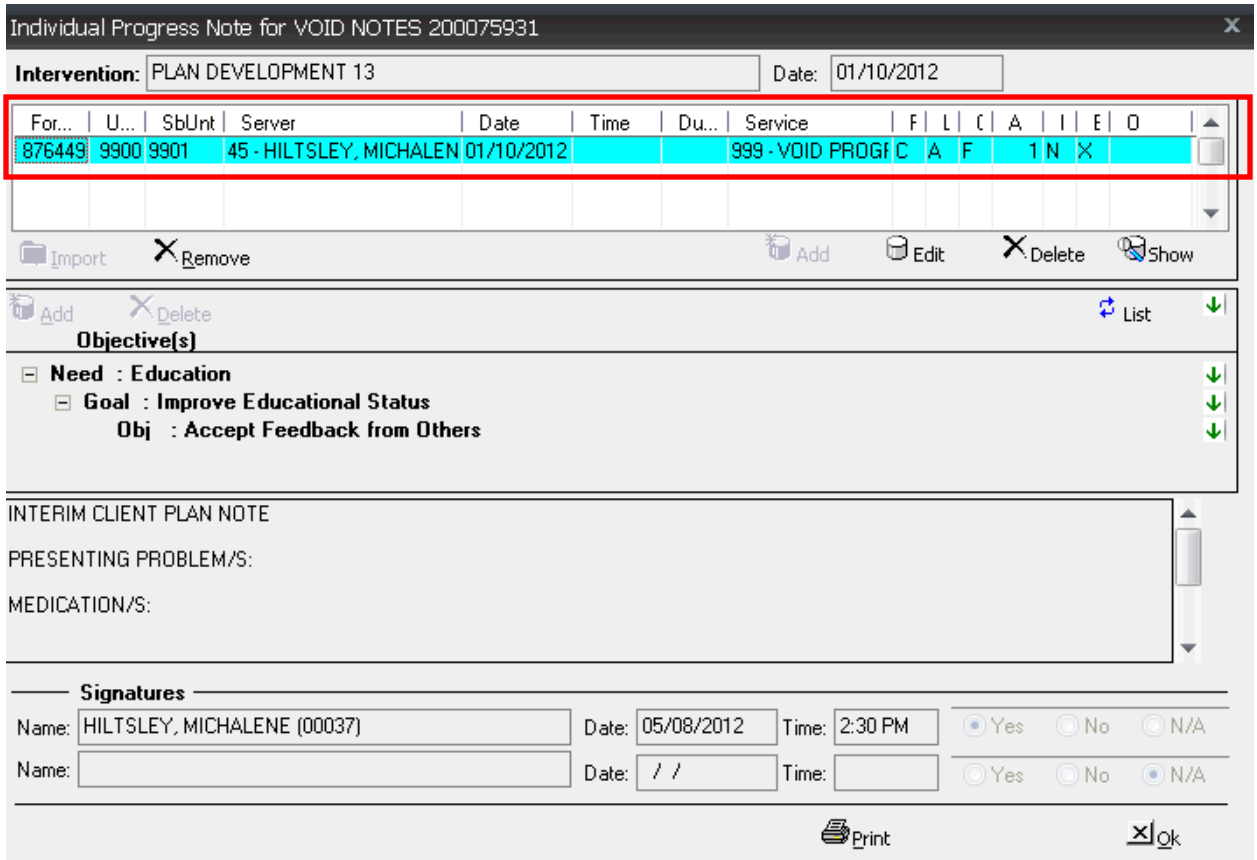
The service will disappear from the service entry portion of the note.



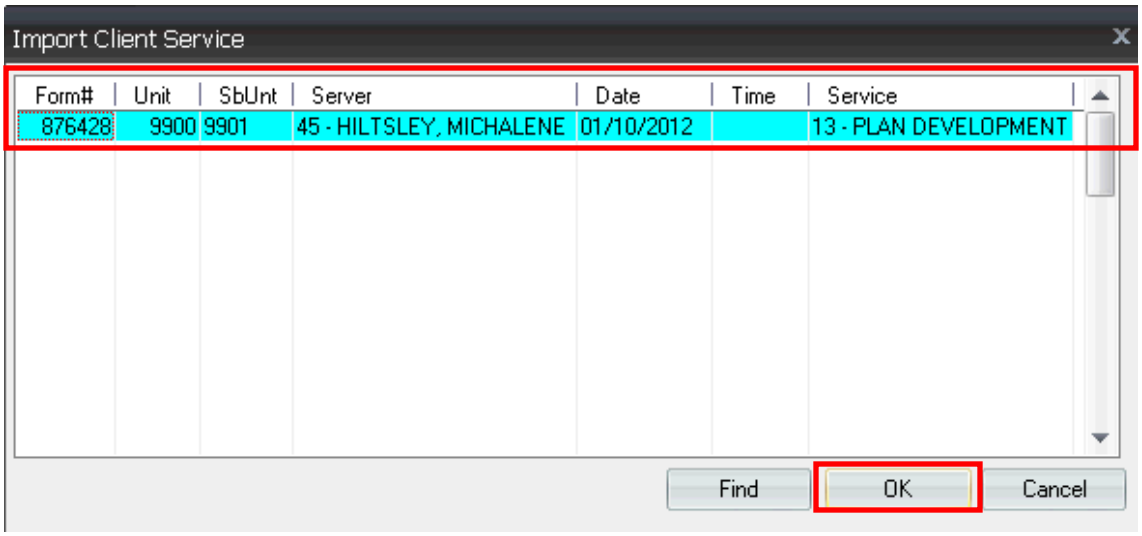
Program clinician **imports** the 999 service entry with the same service date into the progress note. This is done by highlighting the service code 999 service and selecting "Ok".



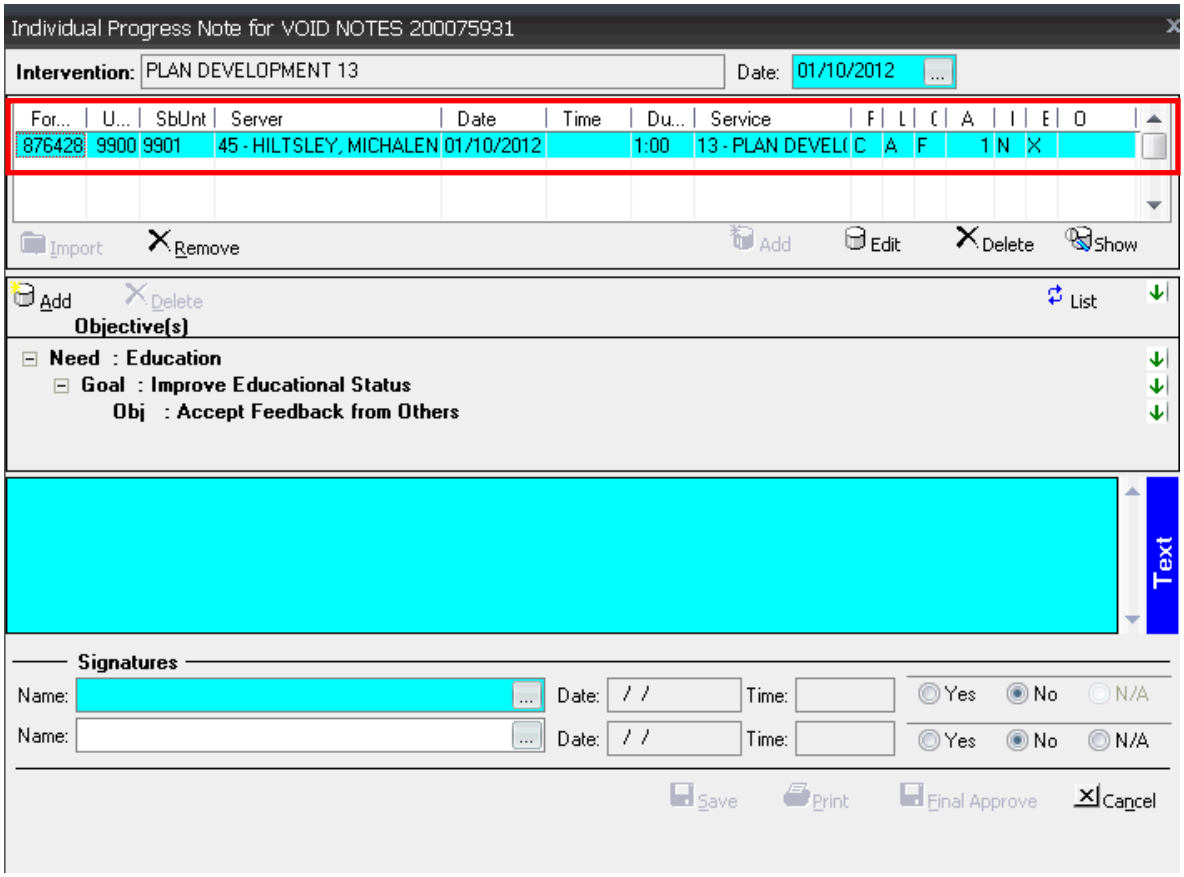
The "Void Progress Note – 999" service will now appear in the service entry portion of the note.



Program contacts Optum Health Support Desk and requests the initial progress note to be voided.
Program clinician enters in new/correct progress note and **imports** the original (removed) service into the new progress note.



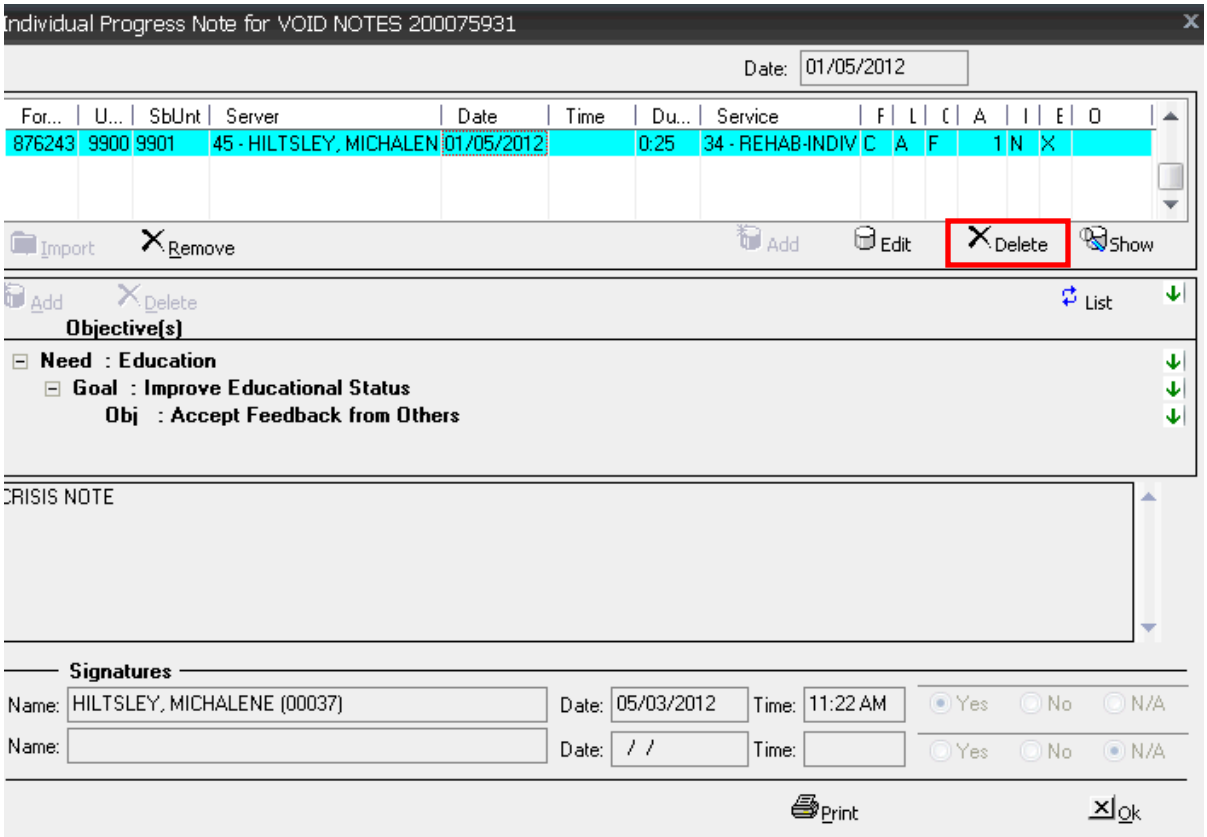
The initial/correct service will now appear in the service entry portion of the note. The clinician will complete the progress note and final approve.

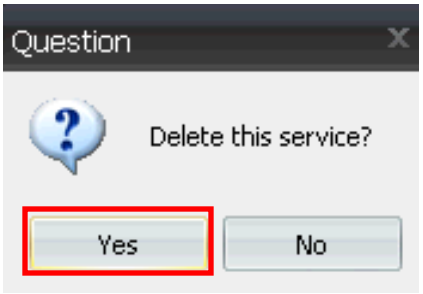


Delete service but keep progress note

Note is final approved AND service is not claimed
(If the date of service is different or the intervention/service code is a planned service from the Client Plan – go to Appendix #5)

Program clinician **deletes** the incorrect service from the progress note.





Program clinician adds/enters in the correct service into the progress note.

Individual Progress Note for VOID NOTES 200075931

Date: 01/05/2012

For...	U...	SbUnt	Server	Date	Time	Du...	Service	F	L	C	A	I	E	O

Import Remove Add Edit Delete Show

Add Delete List

Objective(s)

Need : Education
Goal : Improve Educational Status
Obj : Accept Feedback from Others

CRISIS NOTE

Signatures

Name: HILTSLEY, MICHALENE (00037) Date: 05/03/2012 Time: 11:22 AM Yes No N/A

Name: Date: / / Time: Yes No N/A

Print Ok

Clinician will complete the new service entry portion and select "Save"

Enter/Edit Client Service

Client: NOTES, VOID 2000759 Form #: (blank for new #) Date: 01/05/2012

Unit: TRAINING UNIT 9900 SubUnit: TRAINING SUBUNIT 9901

Loaded Assignment for Unit/SubUnit: 9900/9901 Create Single Contact

Treatment Team:

Server: HILTSLEY, MICHALENE (00037) 45 Supervisor:

Collateral Servers? No Collateral Servers for this Service

Service: CRISIS INTERVENTION 70 70 Lab:

	Start	Duration	Stop
Service:		0:25	
Travel:			
Documentation:			

Days: Quantity:

Participants: Fee:

Provided To: Client C Provided At: Office A

Outside Facility: Contact Type: Face to Face F

App. Type: Unscheduled/Walk-in 2 Billing Type: Not Applicable X

Intensity Type: NOT APPLICABLE N CSI EBP/SS

Save Clear Cancel

The corrected service will display in the service entry portion of the note.

Individual Progress Note for VOID NOTES 200075931

Date: 01/05/2012

For...	U...	SbUnt	Server	Date	Time	Du...	Service	F	L	C	A	I	E	O
876450	9900	9901	45 - HILTSLEY, MICHALEN	01/05/2012		0:25	70 - CRISIS INTEF	C	A	F	2	N	X	

Import Remove Add Edit Delete Show

Add Delete List

Objective(s)

Need : Education
Goal : Improve Educational Status
Obj : Accept Feedback from Others

CRISIS NOTE

Signatures

Name: HILTSLEY, MICHALENE (00037) Date: 05/03/2012 Time: 11:22 AM Yes No N/A

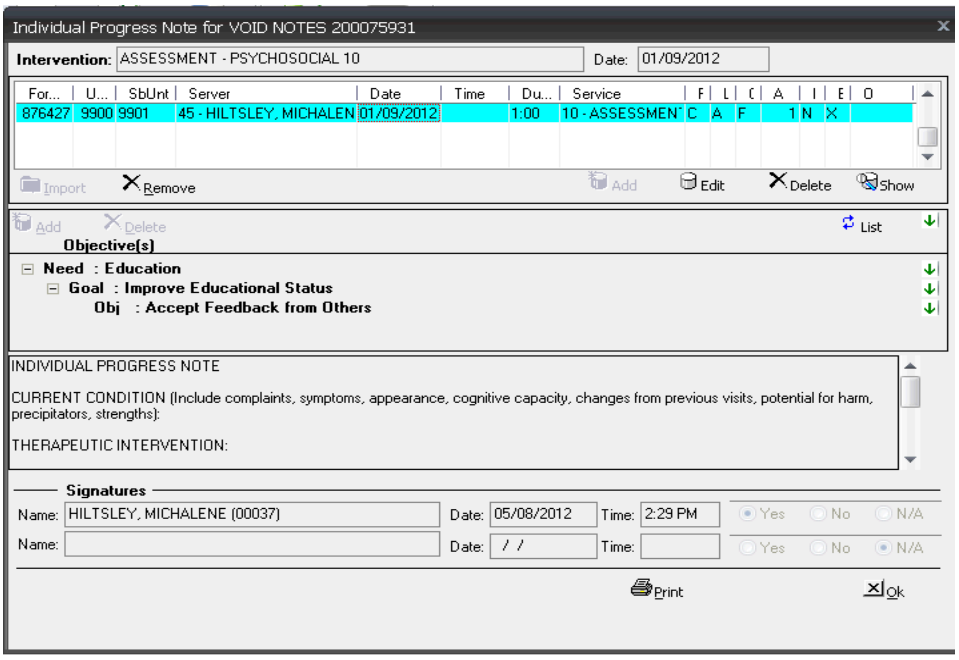
Name: Date: / / Time: Yes No N/A

Print Ok

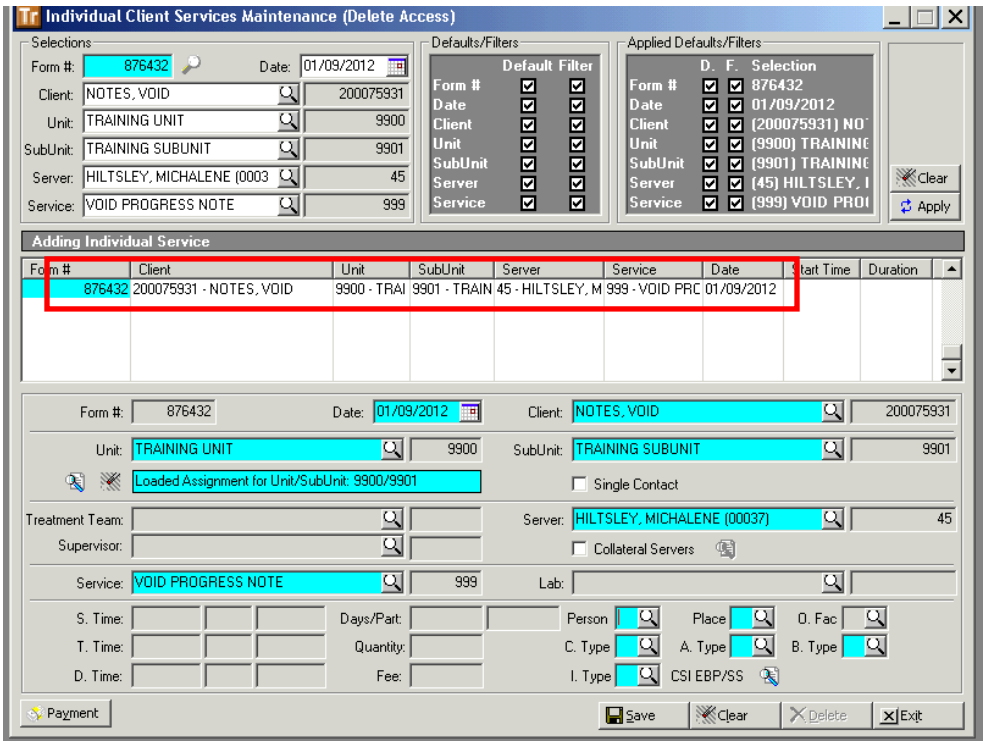
Void progress note and delete the service

The progress note is final approved but is not yet claimed:

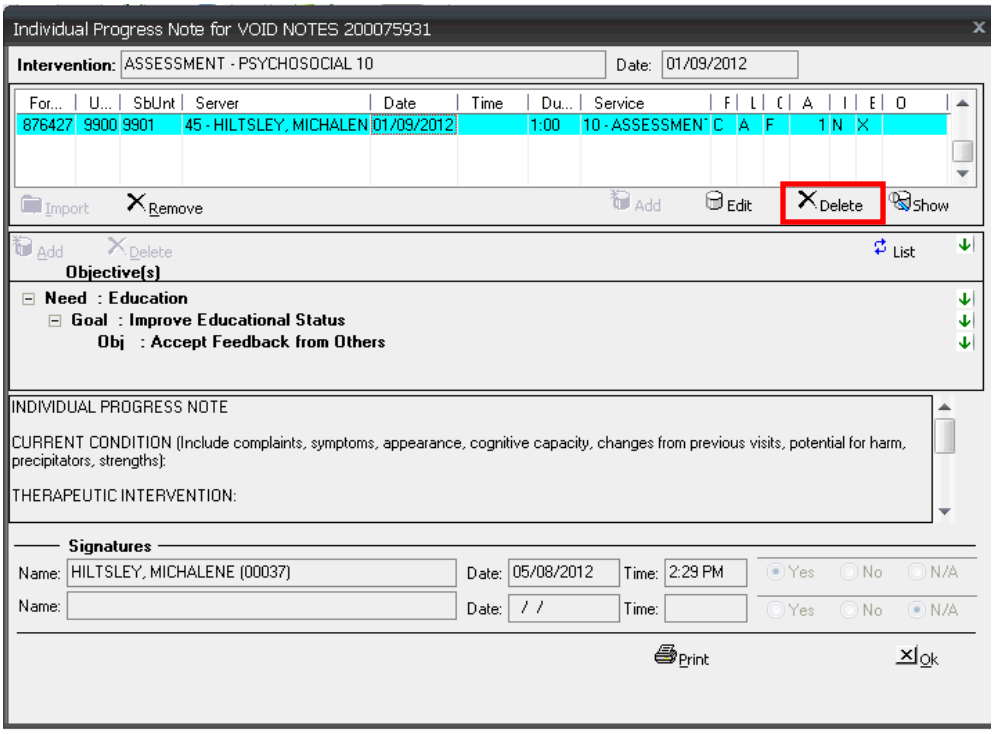
Identify the problem note and service. In this example we have a note for an Assessment service that did not occur on 1/9/12 as it was entered in to the progress note. Because the service did not occur the service must be deleted and the progress note voided.



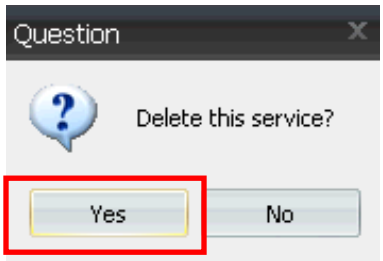
The first step is for the program admin/data entry clerk to enter in a 999 service for the same client on the same date as the initial progress note. This is done through Individual Service Entry.



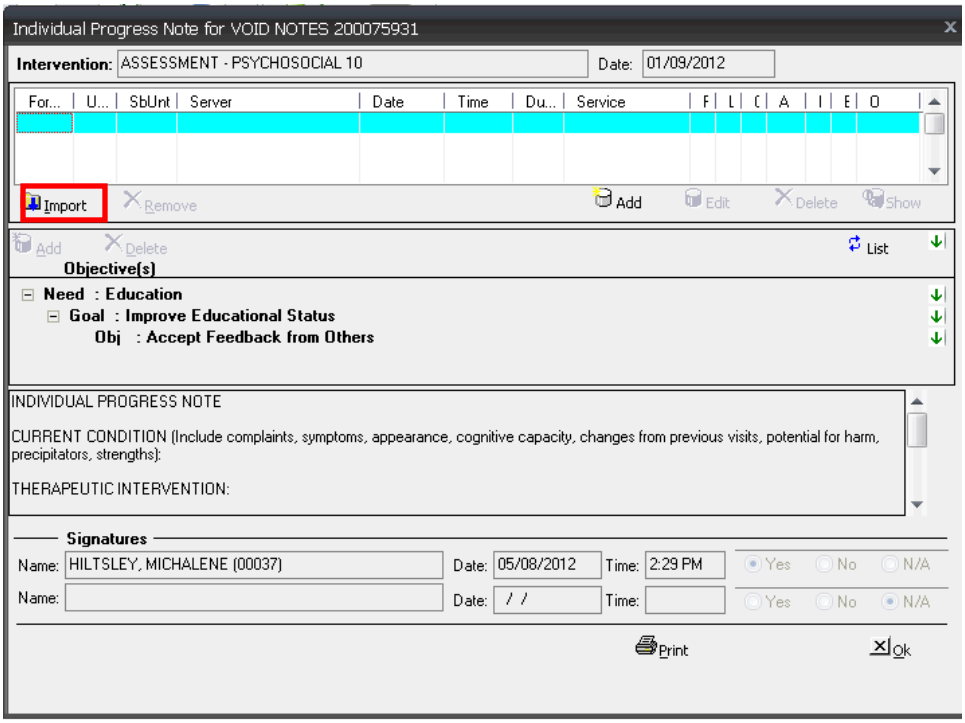
The clinician will locate the wrong note and open it up for edit. The clinician then will "Delete" the initial/wrong service from note.



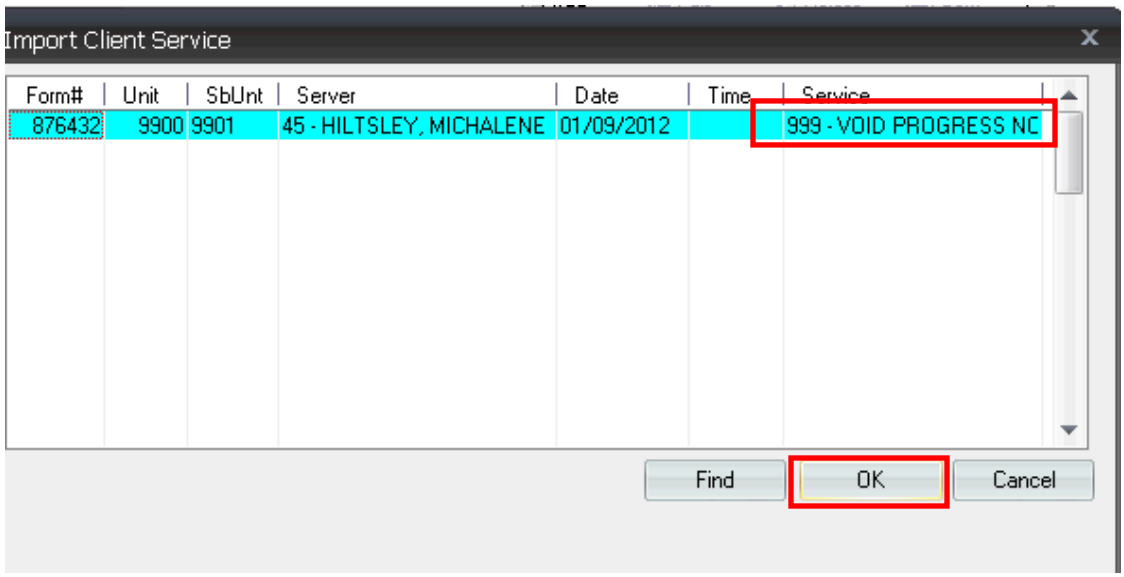
The system will verify that you do want to delete the service – verify that this is the correct service to delete and select "Yes".



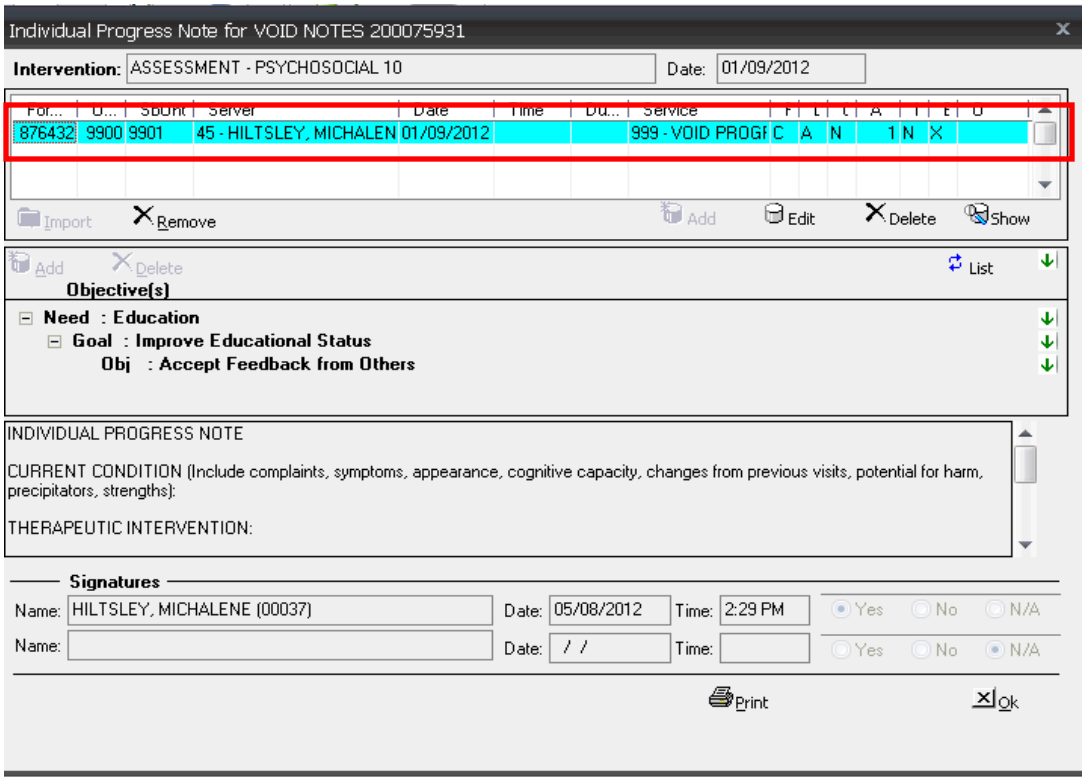
The clinician will then select the “Import” button to locate the 999 service entered by the admin/data entry clerk.



Import “999 – Void Progress Note” in to note – be sure to select the correct service.



Once the void progress note service is imported it will show in the service entry portion of the note. Select “Ok” to close the note.

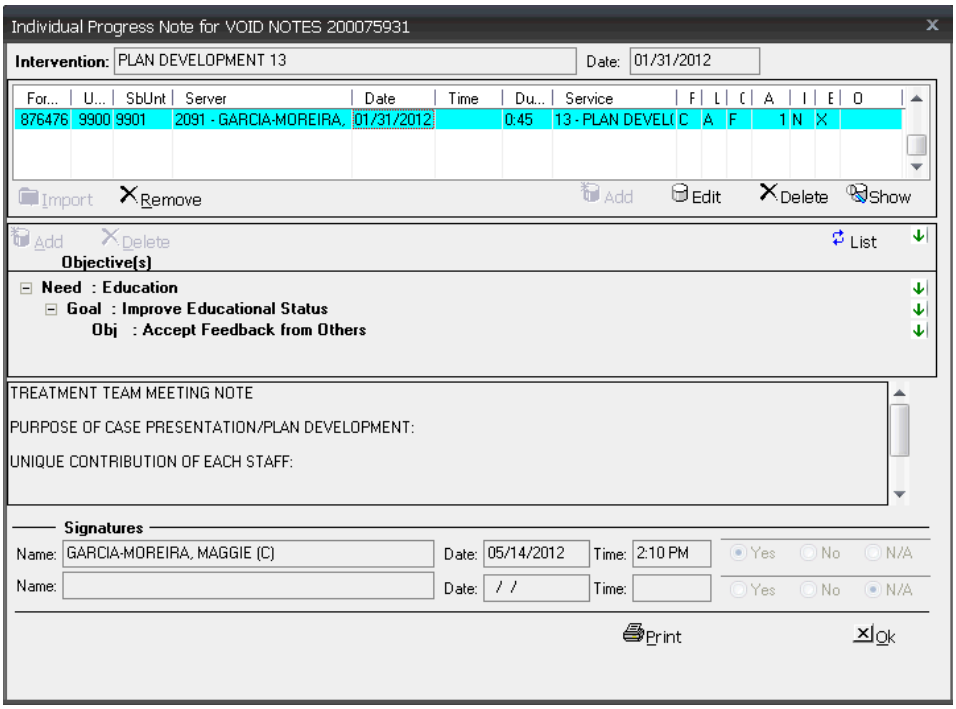


Contact Optum Support Desk and request the note be voided.

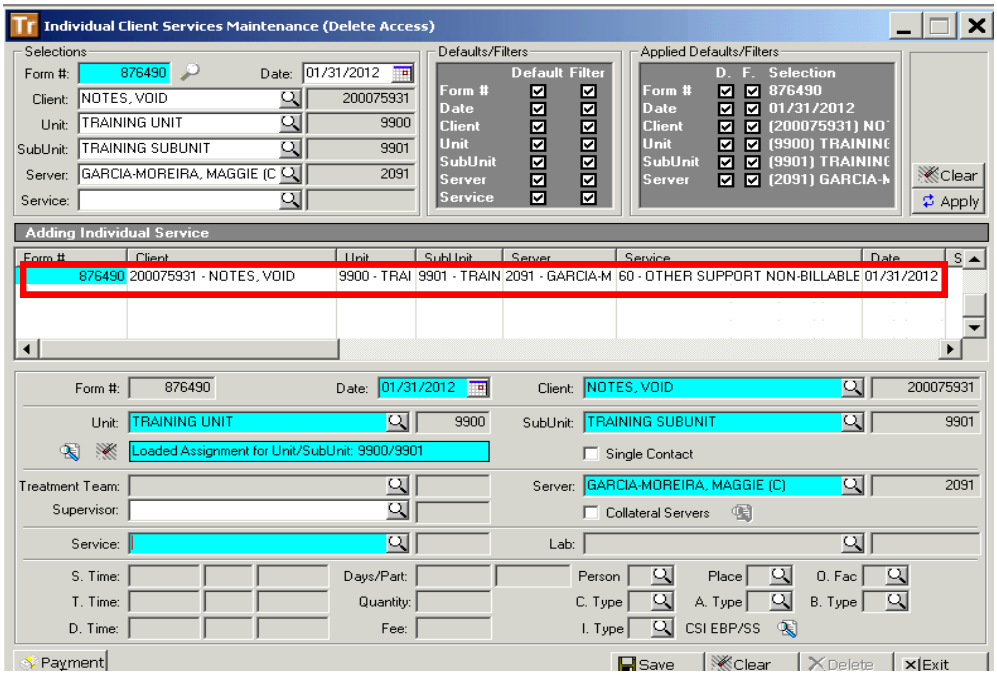
Void service but keep progress note

The note is final approved and the service is claimed.

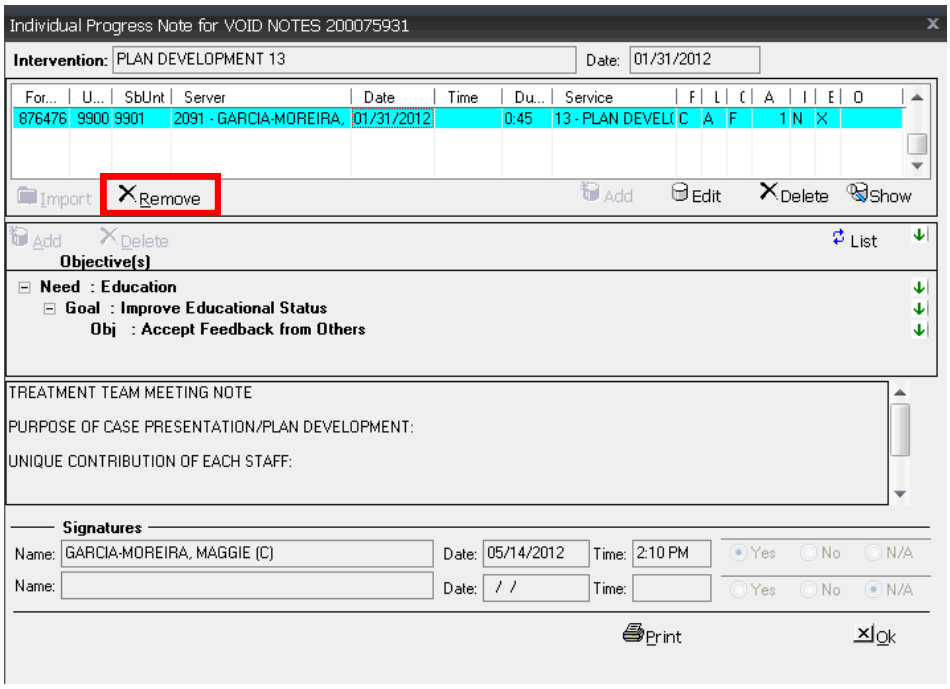
An example of when to use this is when the service entered must be changed to a non-billable service code.



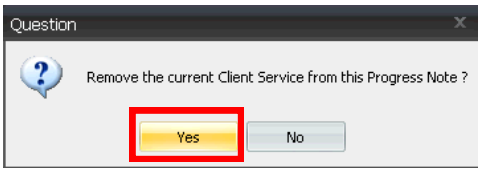
The program admin/data entry clerk will enter in the appropriate non-billable service code for the same client on the same date as the initial date of service. This is done through Individual Service Entry.



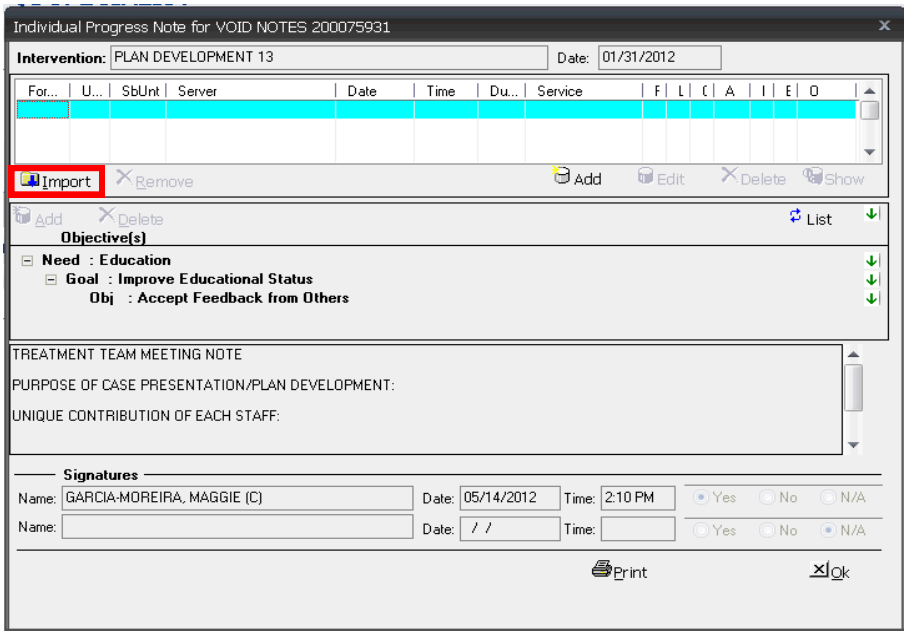
The clinician will locate the wrong note and open it for edits. The clinician then will "Remove" the initial/wrong service from the note.



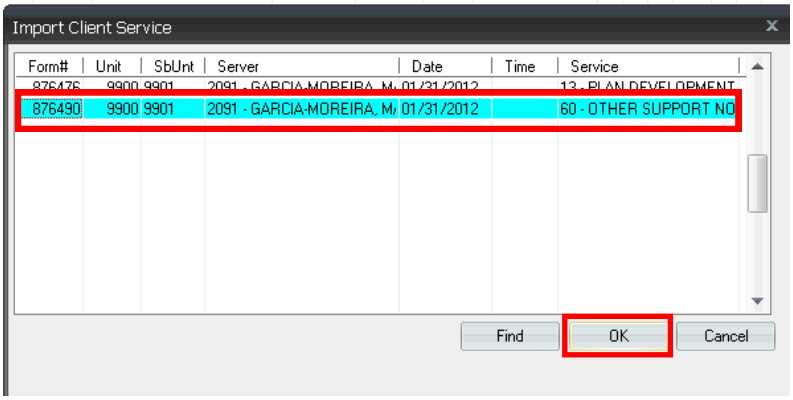
The system will verify that you do want to remove the service-verify that this is the correct service to remove and select, "Yes."



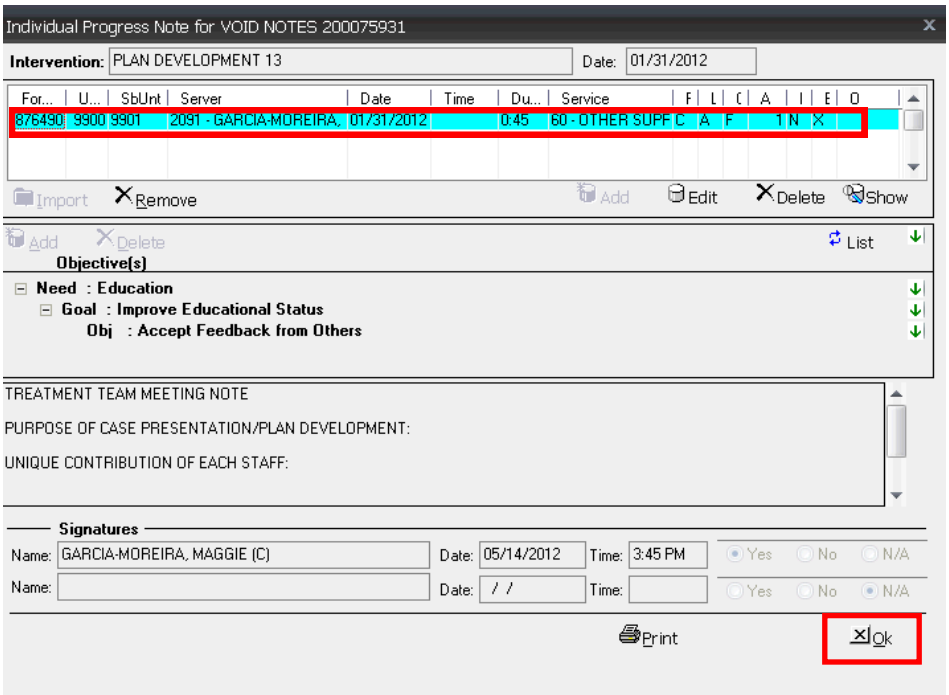
The clinician will then select the "Import" button and locate the "999 – Void Progress Note" service entered by the admin/data entry clerk.



Import the non-billable service in to the note – be sure to select the correct service.



Once the non-billable service is imported it will show in the service entry portion of the note. Select "Ok" to close the note.

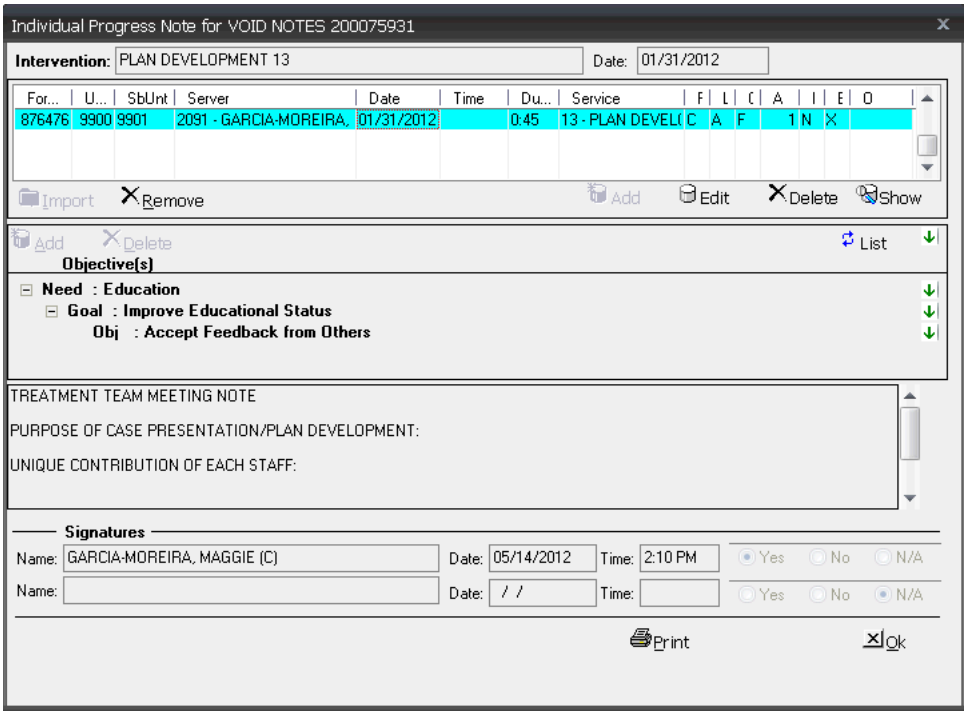


Submit the Void form to MHBU to void the initial incorrect service claimed.

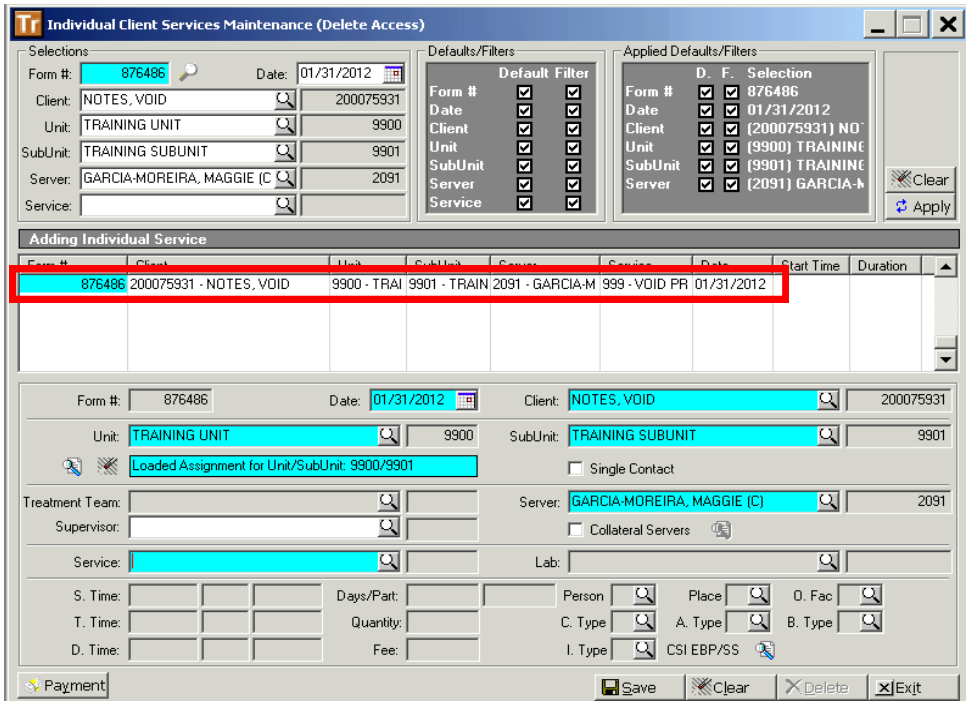
Void progress note and service

The note is final approved and service is claimed.

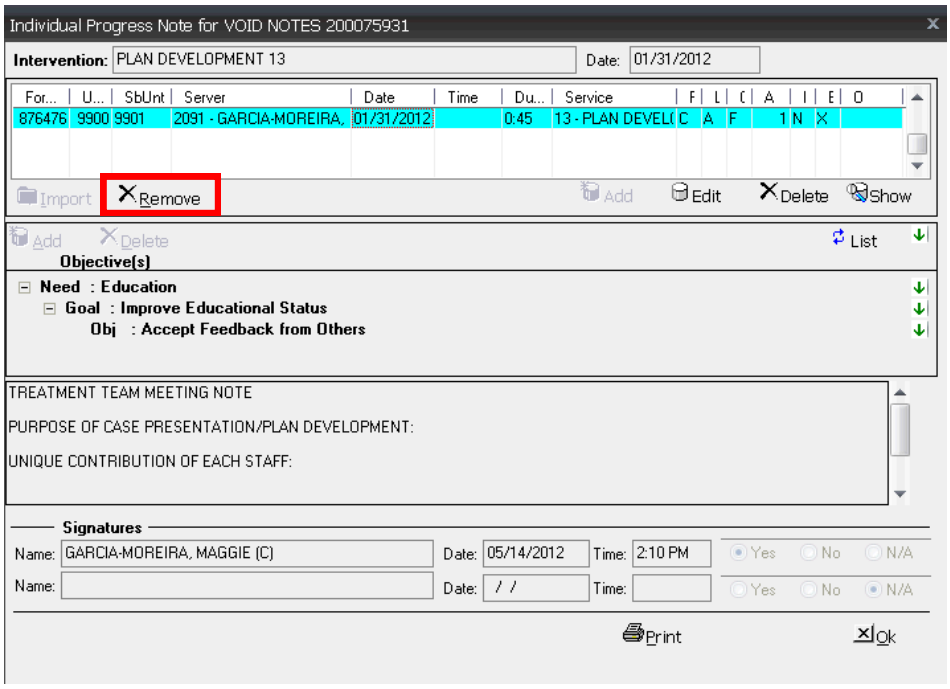
The program admin/data entry clerk will submit the Void form to MHBU.

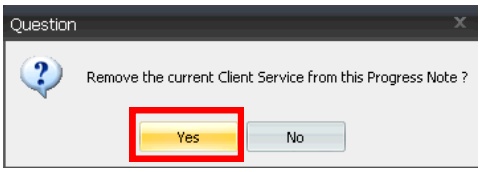


The program admin/data entry clerk will enter in a "999 – Void Progress Note" service for the same client on the same date as the initial progress note. This is done through Individual Service Entry.

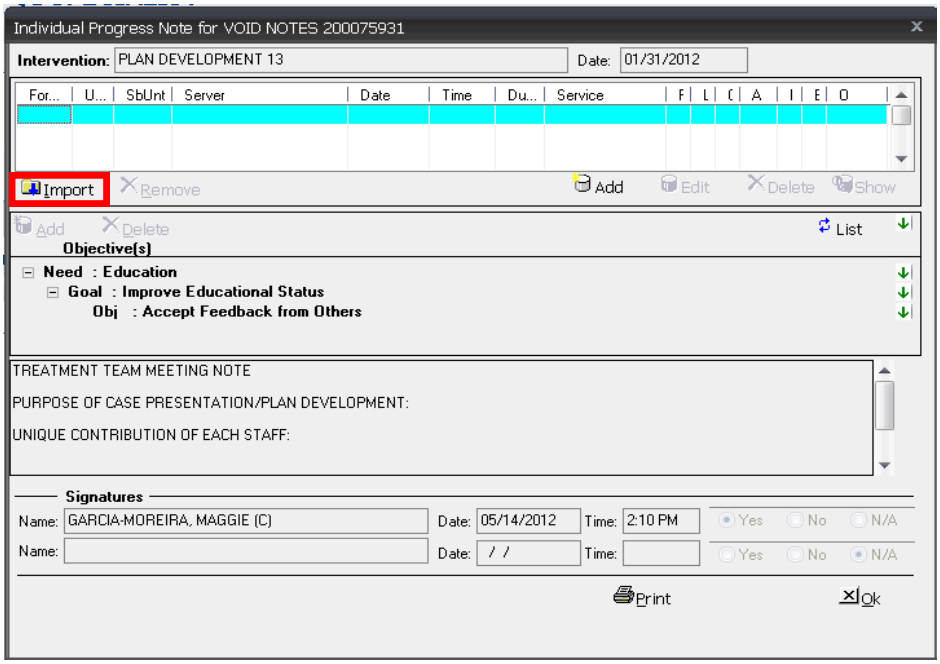


The clinician will locate the wrong note and open it for edit. The clinician then will "Remove" the initial/wrong service from the note.

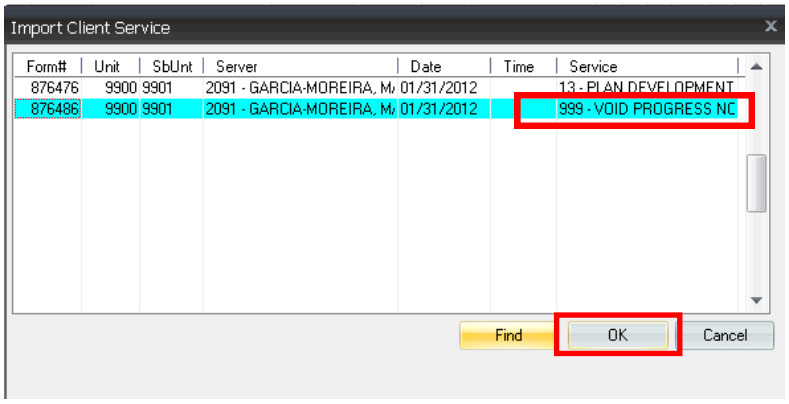




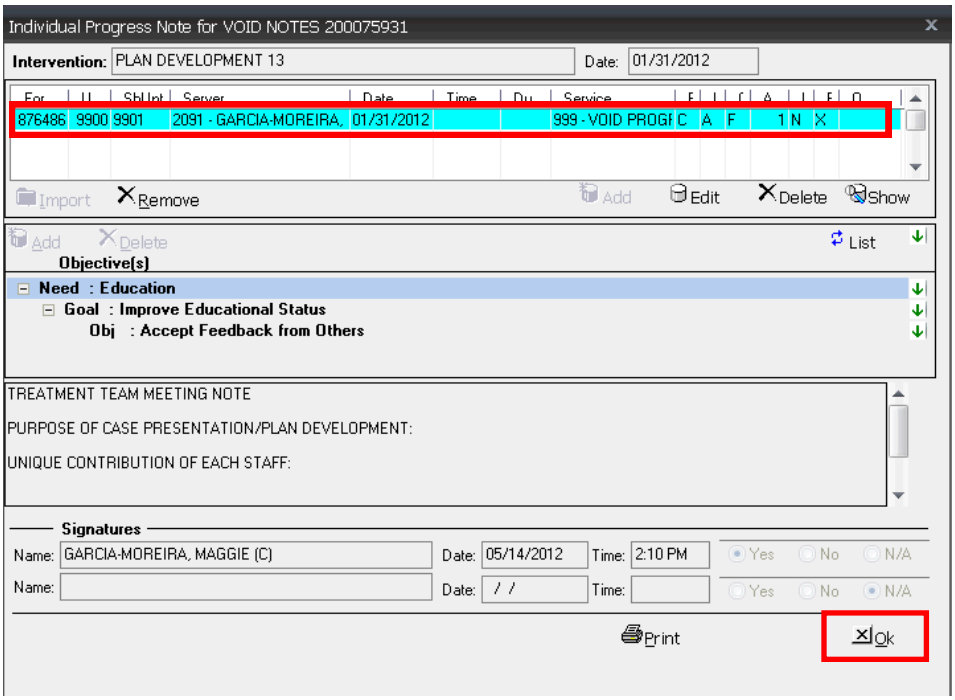
The clinician will import the "999 – Void Progress Note" service entered by the admin/data entry clerk.



Be sure to select the correct service.



Once the"999 - Void Progress Note" service is imported it will show in the service entry portion of the note. Select "Ok" to close the note.



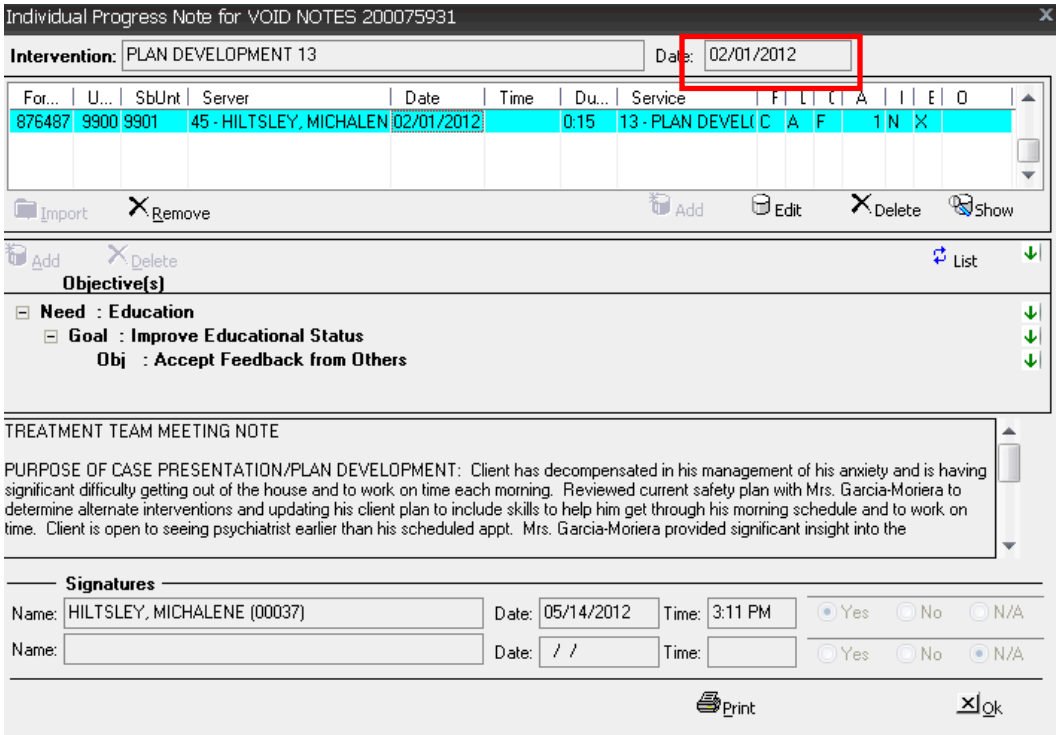
Program will contact Optum Health Support Desk to request the initial progress note be voided.

When the void or replace of service is not an option

Note final approved and service is claimed

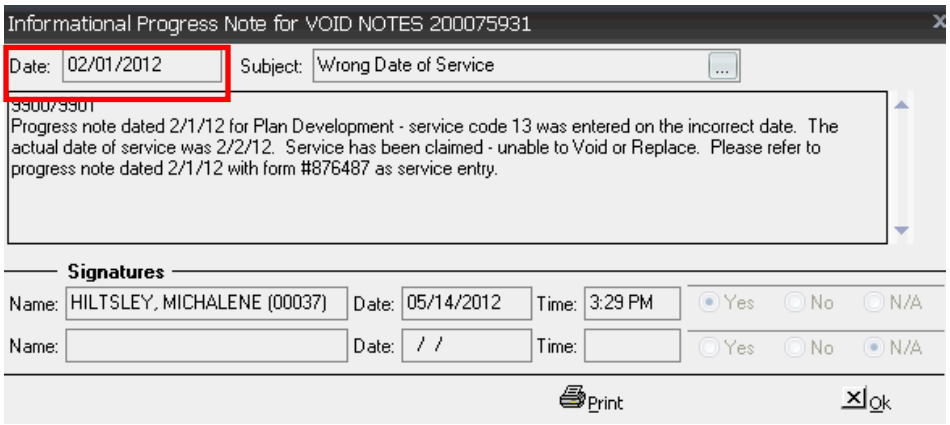
If the service cannot be Voided or Replaced and has been claimed, an Informational Note must be completed.

Example: service was provided on 2/2/12 but the progress note was dated 2/1/12. The service has already been claimed and therefore the service cannot be voided or replaced. An informational note must be attached to the original progress note indicating the wrong date of service.



Add the informational note and include:

- The date the note with the initial note date (this assures that it will file/sort next to the original note)
- The correct Subject heading (in this case 'Wrong Date of Service')
- Unit/SubUnit the note was written for
- The Intervention/Service Code provided
- And the form number for the associated service/claim



The Informational Note will now display next to the progress note with the incorrect date of service. This will allow staff to locate the Informational Note easily for review.

VOID NOTES 200075931 Male Born: 01/01/2001

Progress Notes

Client Plan	Type	F/A	Un	Date	Thru	Intervention
CP Client Plan 01/01/2012-12/31/2012	I - Individual	✓	✓	05/01/2012	05/01/2012	
CP Client Plan 01/01/2012-12/31/2012	I - Individual	✓		02/01/2012	02/01/2012	PLAN DEVELOPMENT 13
CP Client Plan 01/01/2012-12/31/2012	O - Informational	✓		02/01/2012	02/01/2012	
CP Client Plan 01/01/2012-12/31/2012	I - Individual	✓		01/31/2012	01/31/2012	PLAN DEVELOPMENT 13
CP Client Plan 01/01/2012-12/31/2012	I - Individual	✓		01/12/2012	01/12/2012	CASE MGT/ BROKERAGE 50
CP Client Plan 01/01/2012-12/31/2012	I - Individual	✓		01/11/2012	01/11/2012	COLLATERAL 33

MEDICAL

PSYCHIATRIC ASSESSMENT - EHR

2012

WHEN: At the time a client is initially evaluated for medication.

ON WHOM: Every client who is initially evaluated for medication.

COMPLETED BY: MD, DO, MD Trainee.

MODE OF COMPLETION: Data must be entered into the Electronic Health Record.

REQUIRED ELEMENTS: All clinically appropriate elements should be completed.

NOTE: Every assessment within the EHR must be completed and final approved in a timely manner. When it is not completed and final approved (red locked), the system will prevent other servers from launching any assessments that contain shared fields. An assessment that is not final approved (status is "open green locked") is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Assessments are not viewed as complete and active until the assessment is final approved (red locked).

San Diego County Mental Health Services
PSYCHIATRIC ASSESSMENT
Instructions

Anasazi Tab 1

Program Name: Required Field.
Unit Number: Required Field.

PRESENTING PROBLEMS/NEEDS: This is a required field. Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and summary of client's request for services including client's most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors. Include information on 5150 and Police transport.

CLINICAL UPDATE: Document in the space provided. Interval note, describe current presentation and risk assessment to include danger to self and others, reason for visit.

PAST PSYCHIATRIC HISTORY: This is a required field. Previous history of symptoms and/or mental health treatment. Describe in chronological order - where, when, and length of time. Include dates and providers related to any prior psychiatric treatment, history, traumatic and/or significant events, and/or trauma related to treatment. Include the most recent periods of stability and the characteristics of those periods.

SUBSTANCE USE INFORMATION: Required field. Select "No" or "Yes" as it applies to the client. If client indicates "yes," provide information on which substances the client reports in the space provided.

If client declines to report substance use, indicate by checking the appropriate box.

Educate the client regarding the effects of smoking by reading the following statement: "Smoking is a serious health risk that may lead to lung cancer, cardiovascular disease and the possibility of premature death." Indicate that you have provided this advisement by selecting the "Yes" check box.

Use the space provided to document how substance use impacts the client's current level of functioning.

History of Substance Use Treatment: Provide types of treatment, level of care, length of treatment, etc.

Recommendation for Further Substance Use Treatment: Check box "No", "Yes", or "Not Applicable. If "yes," explain in the box provided.

FAMILY HISTORY:

The "Living Arrangement" prompt is Required.

Enter your response on the form based on the Living Arrangement Table below. Include the ID and Description in your documentation.

Living Arrangement		
A-House or Apartment	G-Substance Abuse Residential Rehab Ctr	O-Other
B-House or Apt with Support	H-Homeless/In Shelter	R-Foster Home-Child
C-House or Apt with Daily Supervision Independent Living Facility	I-MH Rehab Ctr (Adult Locked)	S-Group Home-Child (Level 1-12)
D-Other Supported Housing Program	J-SNF/ICF/IMD	T-Residential Tx Ctr-Child (Level 13-14)
E-Board & Care – Adult	K-Inpatient Psych Hospital	U-Unknown
F-Residential Tx/Crisis Ctr – Adult	L-State Hospital	V-Comm Tx Facility (Child Locked)
	M-Correctional Facility	W- Children's Shelter

Those Living In The Home With The Client: List the names and relationship to client in the text box. Include relevant family information impacting the client in the text box provided.

Have Any Relatives Ever Had Any Of The Following Conditions: For each listed condition, enter information from the family members table, if applicable, in the spaces provided. Leave blank if there are none:

ID	DESCRIPTION	ID	DESCRIPTION	ID	DESCRIPTION
Aunt Bio	Aunt – Biological	**Fath InLaw**	Father – In-Law	**Niece NBio**	Niece – Non-biological
Aunt NoBio	Aunt – Non-biological	**Gdaug Bio**	Granddaughter – Biological	**Other**	Other
Bro Adop	Brother – Adopted	**GDaug Nbio**	Granddaughter – Non-biological	**Signif Oth**	Significant Other
Bro Bio	Brother – Biological	**GrFa Bio**	Grandfather – Biological	**Sig Supp**	Significant Support Person
Bro Foster	Brother – Foster	**GrFa NBio**	Grandfather – Non-biological	**Sis Adopt**	Sister – Adopted
Bro InLaw	Brother – In-Law	**GrMo Bio**	Grandmother – Biological	**Sis Bio**	Sister – Biological
Bro Step	Brother – Step	**GrMo Nbio**	Grandmother – Non-biological	**Sis Foster**	Sister – Foster
Cous Bio	Cousin – Biological	**GrSon Bio**	Grandson – Biological	**Sis In Law**	Sister – In-Law
Cous Nbio	Cousin – Non-biological	**GrSon Nbio**	Grandson – Non-biological	**Sis Step**	Sister – Step
Daug Adopt	Daughter – Adopted	**Husband**	Husband	**Son Adopt**	Son – Adopted
Daug Bio	Daughter – Biological	**Mother Ado**	Mother – Adopted	**Son Bio**	Son – Biological
Daug Foster	Daughter – Foster	**Mother Bio**	Mother – Biological	**Son Foster**	Son – Foster
Daug InLaw	Daughter – In-Law	**Mother Fos**	Mother – Foster	**Son In Law**	Son – In-Law
Daug Step	Daughter – Step	**Mo In Law**	Mother – In-Law	**Son Step**	Son – Step
Dom Partner	Domestic Partner	**Mo Step**	Mother – Step	**Uncle Bio**	Uncle - Biological
Fath Adop	Father – Adopted	**Neph Bio**	Nephew – Biological	**Uncl NBio**	Uncle – Non-biological
Fath Bio	Father – Biological	**Neph NBio**	Nephew – Non-biological	**Wife**	Wife
Fath Fost	Father – Foster	**Niece Bio**	Niece – Biological		

Include relevant family information impacting the client: (Further explain family member's involvement in substance use)

MEDICAL HISTORY:

Does client have a Primary Care Physician: This is a required field. Check box "No", "Yes, "Unknown" If No, check "No" or "Yes" client been advised to seek primary care.

Primary Care Physician: Enter the name and phone number of the physician in the text boxes provided.

"Seen within the Last" period of time question is a required field. Check box "6 months", "12 months", or "Other" and explanation in text box provided.

The "Physical Health Issues" prompt is a Required Field. Check boxes for health issues are provided. Check all that apply.

The Allergies and adverse medication reactions" prompt is a Required Field.

Referred to primary health physician: Check box "Yes" or "N/A".

Physical health problems affecting mental health functioning: Explain in text box provided.

Head Injuries: Check box "No" or "Yes". If Yes, specify.

Describe any medical and/or adaptive devices used by client.

Describe any significant developmental information (when applicable).

Allergies and adverse medication reactions is a required field. Check box "No", or "Yes". If yes, specify in text box provided

Other prescription medications: Check box "None" or "Yes". If Yes, describe in text box provided.

Herbals/Dietary Supplements/Over the counter medications: Check box "None" or "Yes". If Yes, describe in text box provided.

Healing and Health: Alternative healing practices and beliefs. Apart from mental health professionals, who or what helps client deal with disability/illness and/or to address substance use issues?

Any known medical condition or past history of abuse that requires special consideration if physical restraint is needed, specifically: breathing problems, significantly overweight, pregnancy, etc? Check box "No", "Yes". If yes, explain.

MMSE: (Mini Mental Status Exam): Enter 2 digit code

Anasazi Tab 2

MENTAL STATUS EXAM : This is a Required Field. Check each area as applicable to client. Document other observations in the space provided.

Anasazi Tab 3

DIAGNOSIS

If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Psychiatric Assessment.

Anasazi Tab 4

VITAL SIGNS: Enter appropriate values for each prompt.

Pain: Check box "No", "Yes", "Unable to determine".

Pain intensity level: Enter information in text box provided.
Location of pain: Enter information in text box provided, and how long client has had pain.
Doctor notified: Enter information in text box provided.

DIAGNOSTIC SUMMARY: Document the summary of your assessment in the space provided.

PLAN: Enter documentation of the Psychosocial/Rehab needs in the space provided. Include available treatment and/or recovery services recommended, within your program or in the community.
.
PRESCRIPTIONS ORDERED NOW: If client is taking psychiatric or psychotropic medications enter in medication table provided in the form.
For "Side Effects Discussed", "Medication Consent Forms", "Ex-Parte" and "Conservator", check boxes "No", "Yes", or "N/A".
Diagnostic Examinations Ordered Now: Enter information in space provided.
Laboratory Tests Ordered Now: Enter information in space provided
Placement Needs: Enter information in space provided

SIGNATURES: Enter the name, credential, date and Anasazi ID number for the Physician requiring a co-signature (if applicable); and/or the Physician completing/accepting the evaluation.

San Diego County Mental Health Services
PSYCHIATRIC ASSESSMENT

*Client Name: _____ *Case Number: _____
*Assessment Date: _____ *Program Name: _____

<u>*CHIEF COMPLAINT/REASON FOR EVALUATION</u>: *Include precipitating factors that led to deterioration/behaviors. Describe events in sequence leading to present visit. Describe primary complaint and summary of client's request for services including client's most recent baseline and a subjective description of the problem/needs. Include observable and measurable impairing behaviors. Include information on 5150 and Police transport.-*

_____
_____
_____
_____
_____
_____
_____

<u>CLINICAL UPDATE</u> *Interval note, describe current presentation and risk assessment to include danger to self and others, reason for visit.*

_____
_____
_____
_____

***PAST PSYCHIATRIC HISTORY**: *Previous history of symptoms and/or mental health treatment. Describe in chronological order - where, when, and length of time. Include dates and providers related to any prior psychiatric treatment, history, traumatic and/or significant events, and/or trauma related to treatment. Include the most recent periods of stability and the characteristics of those periods.-*

_____
_____
_____
_____
_____
_____
_____

Client Name: Case Number:
Assessment Date: Program Name:

SUBSTANCE USE INFORMATION:

***Substance Use?** ☐ **No** ☐ **Yes** ☐ **Client declined to report**

If Yes, specify substances used:

Name of Drug	Priority	Method of Admin-istration	Age 1st used	Freq-uency of Use	Days of use in last 30 days	Date of last use	Amount of last use	Amount used on a typical Day	Largest Amount Used in One Day

The client has been advised that smoking is a serious health risk that may lead to lung cancer, cardiovascular disease and the possibility of premature death: ☐ Yes ☐ N/A

When applicable, outline how substance use impacts current level of functioning:

_____

History of substance use treatment: *Types of treatment, level of care, length of treatment, etc.*

_____
_____
_____
_____

Recommendation for further substance use treatment: ☐ No ☐ Yes ☐Not applicable

If Yes: _____

FAMILY HISTORY:

*Living Arrangement: *Select from Living Arrangement table listed in the Instructions Sheet*

_____

Those living in the home with client: _____

Have any relatives ever had any of the following conditions *Select from Relatives table listed in the Instructions Sheet).*

Substance abuse or addiction: _____
Other addictions: _____
Suicidal thoughts, attempts: _____
Emotional/mental health issues: _____
Mental retardation: _____
Developmental delays: _____
Arrests: _____

Include relevant family information impacting the client:

_____

Client Name: Case Number:
Assessment Date: Program Name:

MEDICAL HISTORY:

*Does client have a Primary Care Physician? ☐No ☐Yes ☐ Unknown
If No, has client been advised to seek primary care? ☐No ☐Yes
Primary Care Physician: _____
Phone Number:_____
Seen within the last: ☐ 6 months ☐ 12 months ☐ Other:_____
Hospital of choice (physical health):_____
Been seen for the following (provide dates of last exam):
Dental exam:_____
Hearing exam:_____
Vision exam:_____

Physical Health issues:

☐ Asthma	☐ Diabetes	☐ Elevated BMI	☐Heart Disease
☐ Hypertension	☐ Kidney Disease	☐ Liver Disease	☐ Neurological
☐ None at This Time	☐Sedentary Lifestyle	☐ Seizure Disorder	☐ Smoking

☐ Other, specify: _____

Referred to primary health physician: ☐ Yes ☐ N/A

Physical health problems affecting mental health functioning:

Head injuries: ☐No ☐Yes, specify:

Medical and/or adaptive devices:

Significant Developmental Information (when applicable):

*Allergies and adverse medication reactions: ☐No ☐Unknown/Not Reported
☐ Yes, specify:

Other prescription medications: ☐ None ☐ Yes:

Herbals/Dietary Supplements/Over the counter medications: ☐ None ☐ Yes:

Healing and Health: *(Alternative healing practices and beliefs. Apart from mental health professionals, who or what helps client deal with disability/illness and/or to address substance use issues? Describe):*

_____
_____
_____

Any known medical condition or past history of abuse that requires special consideration if physical restraint is needed, specifically: breathing problems, significantly overweight, pregnancy, etc? ☐No ☐Yes
If yes, explain:

MMSE: _____

Client Name: Case Number:
Assessment Date: Program Name:

MENTAL STATUS EXAM

☐ Unable to assess at this time.

Level of Consciousness
☐ Alert ☐ Lethargic ☐ Stuporous

Orientation
☐ Person ☐ Place ☐ Day ☐ Month ☐ Year ☐ Current Situation
☐ All Normal ☐ None

Appearance
☐ Good Hygiene ☐ Poor Hygiene ☐ Malodorous ☐ Disheveled
☐ Reddened Eyes ☐ Normal Weight ☐ Overweight ☐ Underweight

Speech
☐ Normal ☐ Slurred ☐ Loud ☐ Soft ☐ Pressured
☐ Slow ☐ Mute

Thought Process
☐ Coherent ☐ Tangential ☐ Circumstantial ☐ Incoherent ☐ Loose Association

Behavior
☐ Cooperative ☐ Evasive ☐ Uncooperative ☐ Threatening ☐ Agitated ☐ Combative

Affect
☐ Appropriate ☐ Restricted ☐ Blunted ☐ Flat ☐ Labile ☐ Other

Intellect
☐ Average ☐ Below Average ☐ Above Average ☐ Poor Vocabulary
☐ Poor Abstraction ☐ Paucity of Knowledge ☐ Unable to Rate

Mood
☐ Euthymic ☐ Elevated ☐ Euphoric ☐ Irritable ☐ Depressed ☐ Anxious

Memory
☐ Normal ☐ Poor Recent ☐ Poor Remote ☐ Inability to Concentrate
☐ Confabulation ☐ Amnesia

Motor
☐ Age Appropriate/Normal ☐ Slowed/Decreased ☐ Psychomotor Retardation
☐ Hyperactive ☐ Agitated ☐ Tremors ☐ Tics ☐ Repetitive Motions

Judgment
☐ Age Appropriate/Normal ☐ Poor ☐ Unrealistic
☐ Fair ☐ Limited ☐ Unable to Rate

Insight
☐ Age Appropriate/Normal ☐ Poor ☐ Fair ☐ Limited ☐ Adequate ☐ Marginal

Command Hallucinations
☐ No ☐ Yes, specify: _____

Auditory Hallucinations
☐ No ☐ Yes, specify: _____

Visual Hallucinations
☐ No ☐ Yes, specify: _____

Client Name: Case Number:
Assessment Date: Program Name:

Tactile Hallucinations
☐ No ☐ Yes, specify: _____

Olfactory Hallucinations
☐ No ☐ Yes, specify: _____

Delusions
☐ No ☐ Yes, specify: _____

Other observations/comments when applicable:
_____

DIAGNOSIS

If making or changing a diagnosis, complete the current Diagnosis Form and attach to this Psychiatric Assessment.

VITAL SIGNS:

Height	Weight	Temp	Resp	Pulse	BP

Pain**:** ☐No ☐Yes ☐Unable to determine
Pain Intensity Level: _____
Location of pain: _____How long: _____

DIAGNOSTIC SUMMARY:
_____
_____
_____
_____
_____
_____

PLAN:
Psychosocial/Rehab Needs: *Other available treatment and/or recovery services recommended, within program or in community*.
_____
_____

Client Name: Case Number:
Assessment Date: Program Name:

Medications (Active and Current Inactivations):

Med	Start Date	Is Date Estima-ted Y or N	Dosage/ Frequency	Amt. Prescribed	Target Sxs	Taken as Pre-scribed? Y, N or Unk	Prescribing Physician Name	**	Refills	Stop Date	Reason for Stopping

***Physician Type**: 1. current psychiatrist (out of network) 2. current PCP 3. previous psychiatrist (out of network) 4. previous PCP*

Side Effects Discussed: ☐No ☐Yes ☐N/A
Medication Consent Forms: ☐No ☐Yes ☐N/A
Ex-Parte: ☐No ☐Yes ☐N/A
Conservator: ☐No ☐Yes ☐N/A

Diagnostic Examinations Ordered Now**:**

_____

Laboratory Tests Ordered Now:

_____

Placement Needs:

_____

Signature of Physician Requiring Co-signature:

_____ _____ _____
Signature Date Time

Printed Name**:** _____ Anasazi ID number: _____

***Signature of Physician Completing/Accepting the Evaluation:**

_____ _____ _____
Signature Date Time

Printed Name**:** _____ Anasazi ID number: _____

Signature of Staff Entering Information (if different from above):

_____ _____ _____
Signature Date Time

Printed Name**:** _____ Anasazi ID number: _____

Abnormal Involuntary Movement Scale (AIMS) - EHR

2012

WHEN: Is not required if information is documented in the progress note.

ON WHOM: All clients receiving anti-psychotic medication. For clients under sixty (60) years of age due once a year and for clients over sixty (60) years of age every six (6) months.

COMPLETED BY: M.D., D.O., or Registered Nurse.

MODE OF COMPLETION: Data must be entered into the Electronic Health Record

REQUIRED ELEMENTS: Facial and oral movements, extremity movements, trunk movements, global judgments, dental status, response to medication.

San Diego County Mental Health Services
ABNORMAL INVOLUNTARY MOVEMENT SCALE
(AIMS)

***Client Name:** _____ ***Case #:** _____

***Date:** _____ ***Program Name:** _____

FACIAL AND ORAL MOVEMENTS

1. Muscles of Facial Expression	☐ None	☐ Minimal	☐ Mild	☐ Moderate	☐ Severe
2. Lips and Perioral Area	☐ None	☐ Minimal	☐ Mild	☐ Moderate	☐ Severe
3. Jaw	☐ None	☐ Minimal	☐ Mild	☐ Moderate	☐ Severe
4. Tongue	☐ None	☐ Minimal	☐ Mild	☐ Moderate	☐ Severe

EXTREMITY MOVEMENTS

5. Upper (Arms, Wrist, Hands, Fingers)	☐ None	☐ Minimal	☐ Mild	☐ Moderate	☐ Severe
6. Lower (Legs, Knees, Ankles, Toes)	☐ None	☐ Minimal	☐ Mild	☐ Moderate	☐ Severe

TRUNK MOVEMENTS

7. Neck, Shoulders, Hips	☐ None	☐ Minimal	☐ Mild	☐ Moderate	☐ Severe

GLOBAL JUDGMENTS

8. Severity of Abnormal Movements	☐ None	☐ Minimal	☐ Mild	☐ Moderate	☐ Severe
9. Incapacity Due to Abnormal Movements	☐ None	☐ Minimal	☐ Mild	☐ Moderate	☐ Severe

10. Patient's Awareness of Abnormal Movements
- ☐ No Awareness
- ☐ Aware, No Distress
- ☐ Aware, Mild Distress
- ☐ Aware, Moderate Distress
- ☐ Aware, Severe Distress

DENTAL STATUS

Current Problems with Teeth, Dentures	☐ Yes	☐ No
Does Client Usually Wear Dentures	☐ Yes	☐ No

TOTAL Tardive Dyskinesia-Like Score _____

Any Other Important Information, Comments or Concerns:

_____
_____
_____
_____

***Signature of Physician or Nurse Completing Examination:**

_____ _____
Signature Date

_____ _____
Printed Name Anasazi ID #

VITAL SIGNS /WEIGHT/HEIGHT RECORD - EHR

2012

WHEN:	Assessment and tracking of physiological parameters is encouraged at every physician visit, when clinic resources allow.
ON WHOM:	Any appropriate client.
COMPLETED BY:	MD, RN, or LVN
MODE OF COMPLETION:	Data must be entered into the Electronic Health Record.
REQUIRED ELEMENTS:	All clinically appropriate elements should be completed.
NOTE:	Every assessment within the EHR must be completed and final approved in a timely manner. When it is not completed and final approved (red locked), the system will prevent other servers from launching any assessments that contain shared fields. An assessment that is not final approved (status is "open green locked") is at risk for deletion by another server. Paper forms are only to be completed when the EHR is not accessible and the expectation is that the information on those forms is entered into the EHR as promptly as possible. Assessments are not viewed as complete and active until the assessment is final approved (red locked).

San Diego County Mental Health Services

VITAL SIGNS/WEIGHT/HEIGHT/RECORD

Client Name: _____ Case #: _____

***Program Name: _____**

History:

Date: _____ Time: _____

Temperature:	
Pulse:	
Respiration:	
Weight	
Height	
Blood Pressure	

Reason taken:

_____
_____
_____
_____
_____

<u>Signature of MD, RN or LVN:</u>

_____ _____ _____
Signature Date Time

_____ _____
Printed Name Anasazi ID #

<u>Signature of Staff:</u>

_____ _____ _____
Signature Date Time

_____ _____
Printed Name Anasazi ID #

Prescriptions/Medications -EHR

2012

Instructions for System Outage

WHEN: Once you have been trained to use the Doctor's Homepage in Anasazi, the expectation is that all medications be entered into Anasazi via the Doctor's Homepage. In the event of a system outage write prescriptions as you would on paper and follow what has been procedure prior to access to DHP. Enter the information into the DHP for the client as the system becomes available. You will not transmit electronically – make sure to mark the prescription method appropriately (handwritten, called in or faxed).

Medical Condition Review Form-EHR

2012

WHEN: Once you have been trained to use the Doctor's Homepage in Anasazi, the expectation is that all new medical condition information be entered into Anasazi via the Doctor's Homepage. In the event of a system outage, this form is used for documenting a client's vitals, allergies and medical condition. Enter the Medical Condition Review into the DHP as soon as the system becomes available again.

ON WHOM: All clients seen by medical staff.

COMPLETED BY: MD or RN supporting the medical staff.

REQUIRED ELEMENTS: All clinically appropriate elements should be completed.

Medical Condition Review

Client Name: _____

Client Number: _____

General

Height: _____ft ____in

Weight: _____lbs ____oz weight circumference _____

☐ Pregnant ☐ Lactating/Nursing ☐ Fathering a child

Vital Signs

Blood pressure: _____ mmHg systolic _____mmHg diastolic

Temperature _____F Heart Rate _____/min Respiratory Rate_____/min

Liver/Renal Conditions

☐ Liver Disease

Renal Function _____ mL/min Dialysis Type _____

Medical Conditions ☐ No Known Medical Conditions

_____

_____

_____

Allergies ☐ No Known Allergies

Include medication and substance allergies

_____

_____

Staff Signature: _____Staff ID: _____

DATE:_____

MENTAL HEALTH SERVICES

2012

CHILDREN'S PROGRAMS

CHILD / YOUTH HISTORY QUESTIONNAIRE - PAPER

2012

WHEN: Within 30 calendar days of opening the client's treatment session. When client has been in the System of Care, the questionnaire should be requested from the prior provider. If the questionnaire is not received prior to the thirty days, a new questionnaire shall be completed.

ON WHOM: All clients (age 0-18) with open cases, receiving services.

COMPLETED BY: Parent / guardian, or significant other. When the client is 18 years or older, emancipated, or when no significant other is available, staff member shall complete the questionnaire by gathering any information that is available.

MODE OF COMPLETION: Legibly handwritten on Child / Youth History Questionnaire form **(**MHS - 651).

REQUIRED ELEMENTS: Name of individual completing the form, their relationship to child and date it was completed. Pregnancy / Birth History, Developmental Milestones, Behavioral Symptom Checklist, Child / Youth Medical History Checklist, Family History, and Child / Youth Mental Health History sections to be filled out as completely as possible with comments when applicable and noting when information is unknown. The questionnaire is to be reviewed, signed, and dated by the primary program staff member.

When the questionnaire is imported from another program or previous episode, the current primary staff shall review, sign, and date the questionnaire.

T Bar shall include the client's name, case number, and program name.

BILLING: Completing the questionnaire and reviewing the responses is often done as part of a session. That contact needs to be summarized in the appropriate progress note format. A service record shall be completed for each progress note entry.

Form Completed By: _____ Relationship To Child: _____ Date Completed: _____

Pregnancy/Birth History

Child's Name: _____ D.O.B: _____ Is Child Adopted: ☐yes ☐no

Did the mother have any medical problems or injuries during pregnancy? ☐yes ☐no ☐ unknown
Describe: _____
Did the mother take any medications during pregnancy? ☐yes ☐no ☐unknown
Describe: _____
Did the mother use any drugs or alcohol during pregnancy? ☐yes ☐no ☐unknown
Describe: _____
Did the mother smoke during pregnancy? ☐yes ☐no ☐unknown
Baby's Birth Weight: _____lbs. _____oz.
Did the mother take the baby home with her when she left the hospital? ☐yes ☐no ☐unknown
Was the pregnancy or delivery unusual or difficult in any way? ☐yes ☐no ☐unknown
Describe: _____
Did the child have any medical problems in infancy? ☐yes ☐no ☐unknown
Describe: _____

Developmental Milestones

Age child first:

crawled _____ sat up alone _____ walked alone _____
first words _____ weaned _____ fed self _____
bladder control _____ bowel trained _____ spoke in complete sentences _____

☐ information is unknown ☐ too long ago to recall ☐ all within normal limits

Behavioral Symptom Checklist

Speech problems	☐ yes	☐ no	☐unknown	Unusual or unrealistic fears	☐ yes	☐ no	☐unknown
Temper tantrums	☐ yes	☐ no	☐unknown	Aggression toward peers	☐ yes	☐ no	☐unknown
Head banging	☐ yes	☐ no	☐unknown	Aggression toward adults	☐ yes	☐ no	☐unknown
Too active	☐ yes	☐ no	☐unknown	Aggression toward animals	☐ yes	☐ no	☐unknown
Impulsive	☐ yes	☐ no	☐unknown	Aggression toward property	☐ yes	☐ no	☐unknown
Stubborn	☐ yes	☐ no	☐unknown	Self-mutilation	☐ yes	☐ no	☐unknown
Day time wetting	☐ yes	☐ no	☐unknown	Physically abused	☐ yes	☐ no	☐unknown
Night time wetting	☐ yes	☐ no	☐unknown	Sexually abused	☐ yes	☐ no	☐unknown
Poor bowel control	☐ yes	☐ no	☐unknown	Sexually active	☐ yes	☐ no	☐unknown
Sleep problems	☐ yes	☐ no	☐unknown	Has sexually molested others	☐ yes	☐ no	☐unknown
Eating problems	☐ yes	☐ no	☐unknown	Suicide attempts	☐ yes	☐ no	☐unknown
Withdrawn, shy	☐ yes	☐ no	☐unknown	Drug use	☐ yes	☐ no	☐unknown
Fire setting	☐ yes	☐ no	☐unknown	Alcohol use	☐ yes	☐ no	☐unknown
Running away	☐ yes	☐ no	☐unknown	Drug or alcohol treatment	☐ yes	☐ no	☐unknown
School truancy	☐ yes	☐ no	☐unknown	Problems with the law	☐ yes	☐ no	☐unknown
School problems	☐ yes	☐ no	☐unknown	Juvenile Hall Stay	☐ yes	☐ no	☐unknown
More interested in things than people	☐ yes	☐ no	☐unknown	Collects/uses weapons	☐ yes	☐ no	☐unknown
				Unusual thoughts	☐ yes	☐ no	☐unknown

Use this area to explain all "yes" answers:

_____
_____
_____

Child / Youth Medical History Checklist

Hearing problems	☐ yes	☐ no
Vision problems	☐ yes	☐ no
Diabetes	☐ yes	☐ no
Ear Infections	☐ yes	☐ no
High fevers	☐ yes	☐ no
TB, last tested: _____	☐ yes	☐ no
Asthma	☐ yes	☐ no
Allergies: _____	☐ yes	☐ no
Seizures or loss of consciousness	☐ yes	☐ no
Serious head injury	☐ yes	☐ no
Other serious injuries	☐ yes	☐ no
Medical Hospitalizations	☐ yes	☐ no
Operations	☐ yes	☐ no
Serious illness	☐ yes	☐ no
Child menstruating	☐ yes	☐ no
Pregnancies, (number: _____)	☐ yes	☐ no
Venereal diseases: _____	☐ yes	☐ no
Do you know child's HIV status	☐ yes	☐ no
Physical exam, date: _____	☐ yes	☐ no
Dental exam, date: _____	☐ yes	☐ no

Use this area to explain all "yes" answers:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Family History

Have any relatives ever had any of the following conditions?

Alcohol problems	☐ yes	☐ no	☐ unknown
Drug problems	☐ yes	☐ no	☐ unknown
Emotional problems	☐ yes	☐ no	☐ unknown
Depression	☐ yes	☐ no	☐ unknown
Developmental Delays	☐ yes	☐ no	☐ unknown
Suicide thoughts	☐ yes	☐ no	☐ unknown
Suicidal attempts	☐ yes	☐ no	☐ unknown
Mentally retarded	☐ yes	☐ no	☐ unknown
Arrests	☐ yes	☐ no	☐ unknown

Family Strengths: _____

Child / Youth Mental Health History

Has the child <u>ever</u> seen a psychiatrist or counselor? ☐ yes ☐ no ☐ unknown

Does the child see a psychiatrist or counselor <u>now</u>? ☐ yes ☐ no Who? _____

What mental health diagnosis has child been given? _____

Has the child ever been on medication for behavioral or emotional problems? ☐ yes ☐ no ☐ unknown

Which medications? _____

Child's Psychiatric Hospitalization(s) History (include dates and reasons): _____

_____

_____

Additional comments: _____

_____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____

Questionario Contestado por: _____ Relación con el niño(a): _____ Fecha en que se contestó: _____

Historia clínica de embarazos / nacimientos

Nombre del niño(a): _____ Fecha de nacimiento: _____ El niño(a) es adoptado(a): ☐sí ☐no

¿Tuvo la madre algún problema médico o lesiones durante el embarazo? ☐ sí ☐no ☐ se desconoce
Describa: _____

¿Tomó la madre algún medicamento durante el embarazo? ☐ sí ☐no ☐ se desconoce
Describa: _____

¿Consumió la madre drogas o alcohol durante el embarazo? ☐ sí ☐no ☐ se desconoce
Describa _____

¿Fumó la madre durante el embarazo? ☐ sí ☐no ☐ se desconoce
Peso del bebé al nacer: _____libras _____onzas

¿La madre y el bebé salieron del hospital al mismo tiempo? ☐ sí ☐no ☐ se desconoce

¿Fue el embarazo o el nacimiento difícil o inusual de alguna manera? ☐ sí ☐no ☐ se desconoce
Describa: _____

¿Tuvo algún problema médico el niño(a) durante su infancia? ☐ sí ☐no ☐ se desconoce
Describa: _____

Metas de desarrollo

Edad en la que el niño(a) comenzó a:

gatear _____ sentarse solo(a) _____ caminar solo(a) _____
primeras palabras _____ dejo pecho/biberon _____ comer solo(a) _____
ir al baño solo (orinar) _____ ir al baño solo (materia fecal/popo)_____ decir oraciones completas _____

☐ se desconoce la información ☐ demasiado tiempo atrás, no recuerda ☐ dentro de los límites normales

Síntomas de comportamiento

Problemas del lenguaje	☐ sí	☐ no	☐se desconoce
Rabietas/berrinches	☐ sí	☐ no	☐ se desconoce
Golpearse la cabeza	☐ sí	☐ no	☐ se desconoce
Demasiada actividad	☐ sí	☐ no	☐ se desconoce
Impulsividad	☐ sí	☐ no	☐ se desconoce
Terquedad	☐ sí	☐ no	☐ se desconoce
Orinarse durante el día	☐ sí	☐ no	☐ se desconoce
Orinarse durante la noche	☐ sí	☐ no	☐ se desconoce
Hacerse del bano en si mismo	☐ sí	☐ no	☐ se desconoce
Problemas para dormir	☐ sí	☐ no	☐ se desconoce
Problemas alimenticios	☐ sí	☐ no	☐ se desconoce
Retraimiento, timidez	☐ sí	☐ no	☐ se desconoce
Provocar incendios	☐ sí	☐ no	☐ se desconoce
Escaparse de casa	☐ sí	☐ no	☐ se desconoce
Ausentismo escolar	☐ sí	☐ no	☐ se desconoce
Problemas en la escuela	☐ sí	☐ no	☐ se desconoce
Muestra más interés en cosas que en personas	☐ sí	☐ no	☐ se desconoce

Miedos inusuales e irreales	☐ sí	☐ no	☐ se desconoce
Agresividad hacia compañeros	☐ sí	☐ no	☐ se desconoce
Agresividad hacia adultos	☐ sí	☐ no	☐ se desconoce
Agresividad hacia animales	☐ sí	☐ no	☐ se desconoce
Agresividad hacia cosas materiales	☐ sí	☐ no	☐ se desconoce
Auto mutilación	☐ sí	☐ no	☐ se desconoce
Maltrato físico	☐ sí	☐ no	☐ se desconoce
Abuso sexual	☐ sí	☐ no	☐ se desconoce
Sexualmente activo(a)	☐ sí	☐ no	☐ se desconoce
Ha molestado sexualmente a otros	☐ sí	☐ no	☐ se desconoce
Intentos de suicidio	☐ sí	☐ no	☐ se desconoce
Consumo de drogas	☐ sí	☐ no	☐ se desconoce
Consumo de alcohol	☐ sí	☐ no	☐ se desconoce
Tratamiento por alcohol o drogas	☐ sí	☐ no	☐ se desconoce
Problemas con la ley	☐ sí	☐ no	☐ se desconoce
Permanencia en el Tribunal para menores	☐ sí	☐ no	☐ se desconoce
Colecciona o utiliza armas	☐ sí	☐ no	☐ se desconoce
Pensamientos raros	☐ sí	☐ no	☐ se desconoce

Utilice esta área para explicar todas las respuestas que contestaron "si":

_____
_____
_____

Historia clínica del niño(a)/joven

Problemas de oir	☐ sí	☐ no
Problemas de la vista	☐ sí	☐ no
Diabetes	☐ sí	☐ no
Infecciones de oídos	☐ sí	☐ no
Fiebre alta	☐ sí	☐ no
Última vez que se hizo la prueba de la tuberculosis (TB): _____	☐ sí	☐ no
Asma	☐ sí	☐ no
Alergias: _____	☐ sí	☐ no
Convulsiones o pérdida del conocimiento	☐ sí	☐ no
Lesiones graves en la cabeza	☐ sí	☐ no
Otras lesiones graves	☐ sí	☐ no
Hospitalizaciones médicas	☐ sí	☐ no
Operaciones	☐ sí	☐ no
Enfermedades graves	☐ sí	☐ no
Menstruación	☐ sí	☐ no
Embarazos, (número: _____)	☐ sí	☐ no
Enfermedades venéreas: _____	☐ sí	☐ no
Sabe la condición de VIH del niño(a)	☐ sí	☐ no
Examen físico, fecha: _____	☐ sí	☐ no
Examen dental, fecha: _____	☐ sí	☐ no

Utilice esta área para explicar todas las respuestas contesto "si":

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Antecedentes familiares

¿Alguno de sus parientes ha tenido alguna vez alguna de las condiciones siguientes?

Problemas con el alcohol	☐ sí	☐ no	☐ se desconoce
Problemas con drogas	☐ sí	☐ no	☐ se desconoce
Problemas emocionales	☐ sí	☐ no	☐ se desconoce
Depresión	☐ sí	☐ no	☐ se desconoce
Retrasos en el desarrollo	☐ sí	☐ no	☐ se desconoce
Pensamientos suicidas	☐ sí	☐ no	☐ se desconoce
Intentos de suicidio	☐ sí	☐ no	☐ se desconoce
Retraso mental	☐ sí	☐ no	☐ se desconoce
Arrestos	☐ sí	☐ no	☐ se desconoce

Cosas buenas de la familia: _____

_____

Antecedentes de salud mental del niño(a) / joven

¿Ha visto alguna vez a un psiquiatra o consejero el niño(a)? ☐ sí ☐ no ☐ se desconoce

¿En este momento el niño(a) ve a un psiquiatra o consejero? ☐ sí ☐ no ¿a quién? _____

¿Cuál ha sido el diagnóstico de salud mental que le han dado? _____

¿Ha tomado el niño(a) alguna vez medicamento por problemas emocionales o de comportamiento? ☐ sí ☐ no ☐ se desconoce

¿Qué medicamentos? _____

Historia de hospitalización(es) psiquiátrica(s) del niño(a) (incluya fechas y motivos): _____

_____

_____

Comentarios adicionales: _____

_____

Revisado por: _____ Fecha: _____

Revisado por: _____ Fecha: _____

Revisado por: _____ Fecha: _____

Revisado por: _____ Fecha: _____

Revisado por: _____ Fecha: _____

تمت تعبئة الإستمارة من قبل: _____ العلاقة بالطفل: _____ تأريخ تعبئة الإستمارة: _____

سجل حالة الحمل و الولادة

إسم الطفل: _____ تأريخ الميلاد: _____ هل تم تبني الطفل؟ ☐ نعم ☐ لا

هل عانت الأم من أي مشاكل صحية أو إصابات أثناء الحمل؟ ☐ نعم ☐ لا ☐ لا أعلم

إشرح ذلك: _____

هل كانت الأم تتناول أي عقاقير أو أدوية خلال فترة الحمل؟ ☐ نعم ☐ لا ☐ لا أعلم

إشرح ذلك: _____

هل كانت الأم تتعاطى المخدرات أو الكحول أثناء الحمل؟ ☐ نعم ☐ لا ☐ لا أعلم

إشرح ذلك: _____

هل كانت الأم تدخن أثناء الحمل؟ ☐ نعم ☐ لا ☐ لا أعلم

وزن الطفل عند الولادة: _____ رطل (باوند) _____ أوقية (أونسة)

هل أخذت الأم الطفل معها عندما غادرت المستشفى؟ ☐ نعم ☐ لا ☐ لا أعلم

هل كانت فترة الحمل أو الولادة غير إعتيادية أو صعبة بأي شكل من الأشكال؟ ☐ نعم ☐ لا ☐ لا أعلم

إشرح ذلك: _____

هل عانى الطفل من أي مشاكل صحية خلال فترة الطفولة الأولى؟ ☐ نعم ☐ لا ☐ لا أعلم

إشرح ذلك: _____

مراحل النمو

العمر الذي بدء به الطفل بـ:

الزحف: _____ الجلوس لوحده دون مساعدة: _____ المشي لوحده دون مساعدة: _____

التفوه بكلماته الأولى: _____ الفطام (التوقف عن تناول حليب الأم): _____ تناول الطعام بنفسه: _____

التحكم بمثانته (التبول): _____ التحكم بوقت التبرز: _____ تكلم بجملة كاملة و مفيدة: _____

☐ المعلومات غير متوفرة ☐ مضت فترة طويلة و لا أستطيع التذكر ☐ تمت جميع المراحل المذكورة أعلاه بالأوقات الطبيعية

قائمة خيارات الأعراض السلوكية

لديه مشاكل في التكلم	☐	نعم	لا	لا أعلم	لديه خوف غير طبيعي أو غير منطقي	☐	نعم	لا	لا أعلم
تصيبه نوبات غضب مزاجية	☐	نعم	لا	لا أعلم	عنيف تجاه أقرانه	☐	نعم	لا	لا أعلم
يضرب رأسه	☐	نعم	لا	لا أعلم	عنيف تجاه البالغين	☐	نعم	لا	لا أعلم
لديه زيادة في النشاط (الفاعلية)	☐	نعم	لا	لا أعلم	عنيف تجاه الحيوانات	☐	نعم	لا	لا أعلم
متهور	☐	نعم	لا	لا أعلم	عنيف تجاه الممتلكات	☐	نعم	لا	لا أعلم
عنيد	☐	نعم	لا	لا أعلم	يؤذي نفسه	☐	نعم	لا	لا أعلم
يتبول لا إرادياً في النهار	☐	نعم	لا	لا أعلم	تعرض للإستغلال الجسدي	☐	نعم	لا	لا أعلم
يتبول لا إرادياً في الليل	☐	نعم	لا	لا أعلم	تعرض للإستغلال الجنسي	☐	نعم	لا	لا أعلم
لا يستطيع التحكم بحركة الأمعاء (التغوط)	☐	نعم	لا	لا أعلم	نشط جنسياً	☐	نعم	لا	لا أعلم
لديه مشاكل في النوم	☐	نعم	لا	لا أعلم	تحرش جنسياً بالأخرين	☐	نعم	لا	لا أعلم
لديه مشاكل في تناول الطعام	☐	نعم	لا	لا أعلم	حاول الإنتحار	☐	نعم	لا	لا أعلم
خجول، يخاف من الإختلاط	☐	نعم	لا	لا أعلم	تعاطى المخدرات	☐	نعم	لا	لا أعلم
يحب إشعال النيران	☐	نعم	لا	لا أعلم	تناول المشروبات الروحية (الكحول)	☐	نعم	لا	لا أعلم
حاول الهروب	☐	نعم	لا	لا أعلم	تعالج من إدمان الكحول أو المخدرات	☐	نعم	لا	لا أعلم
يتغيب عن المدرسة	☐	نعم	لا	لا أعلم	لديه مشاكل مع القانون	☐	نعم	لا	لا أعلم
لديه مشاكل في المدرسة	☐	نعم	لا	لا أعلم	أجبر على البقاء في إصلاحية القاصرين	☐	نعم	لا	لا أعلم
يهتم بالأشياء أكثر من الأشخاص	☐	نعم	لا	لا أعلم	يقتني أو يستعمل الأسلحة	☐	نعم	لا	لا أعلم
					لديه أفكار غير طبيعية	☐	نعم	لا	لا أعلم

إستخدم المجال أدناه لشرح جميع النقاط التي أجبت عنها بنعم أعلاه

_____

_____

_____

قائمة خيارات سجل الحالة الصحية أثناء مرحلتي الطفولة و الشباب

إستخدم المجال أدناه لشرح جميع النقاط التي أجبت عنها بنعم

مشاكل في السمع	☐ نعم	☐ لا
مشاكل في النظر و القدرة على الإبصار	☐ نعم	☐ لا
داء السكري	☐ نعم	☐ لا
إلتهاب الأذن	☐ نعم	☐ لا
حمى شديدة	☐ نعم	☐ لا
مصاب بالسل، تأريخ أخر فحص _____	☐ نعم	☐ لا
الربو	☐ نعم	☐ لا
حساسية _____	☐ نعم	☐ لا
الصرع أو فقدان الوعي	☐ نعم	☐ لا
إصابات خطيرة في الرأس	☐ نعم	☐ لا
إصابات خطيرة أخرى	☐ نعم	☐ لا
الإقامة في المستشفى	☐ نعم	☐ لا
العمليات الجراحية	☐ نعم	☐ لا
الأمراض الخطيرة	☐ نعم	☐ لا
الحيض المبكر (الدورة الشهرية أثناء عمر الطفولة)	☐ نعم	☐ لا
حالات الحمل، (عددها _____)	☐ نعم	☐ لا
الأمراض التناسلية _____	☐ نعم	☐ لا
هل تعلم ما هو موقف طفلك من فايروس نقص المناعة المكتسب (الأيدز أو السيدا)	☐ نعم	☐ لا
تأريخ أخر فحص طبي _____	☐ نعم	☐ لا
تأريخ أخر فحص أسنان _____	☐ نعم	☐ لا

سجل حال الصحة العائلية

هل مر أحد أفراد عائلتك بأحد الفقرات التالية؟

الإدمان على الكحول	☐ نعم	☐ لا	لا أعلم	التفكير بالإنتحار	☐ نعم ☐ لا لا أعلم
الإدمان على المخدرات	☐ نعم	☐ لا	لا أعلم	محاولة الإنتحار	☐ نعم ☐ لا لا أعلم
مشاكل عاطفية (أو نفسية)	☐ نعم	☐ لا	لا أعلم	التخلف العقلي	☐ نعم ☐ لا لا أعلم
الكآبة	☐ نعم	☐ لا	لا أعلم	الإعتقال	☐ نعم ☐ لا لا أعلم
تأخر في النمو	☐ نعم	☐ لا	لا أعلم		

نقاط قوة العائلة: _____

سجل الصحة النفسية في مرحلتي الطفولة و الشباب

هل زار الطفل الطبيب النفسي أو المرشد الإجتماعي؟ ☐ نعم ☐ لا لا أعلم

هل يزور الطفل حالياً الطبيب النفسي أوالمرشد الأجتماعي؟ ☐ نعم ☐ لا لا أعلم من؟ _____

ما هو تشخيص حالة طفلك النفسية؟ _____

هل وصف لطفلك من قبل أي عقار أو دواء للمشاكل النفسية أو السلوكية؟ ☐ نعم ☐ لا لا أعلم

ما هو الدواء أو العقار الموصوف؟ _____

حالات إقامة طفلك في المستشفى النفسي (إذكر التواريخ و الأسباب التي دعت لذلك): _____

أي تعليقات إضافية: _____

تمت مراجعة هذه الوثيقة من قبل: _____ التأريخ: _____

تمت مراجعة هذه الوثيقة من قبل: _____ التأريخ: _____

تمت مراجعة هذه الوثيقة من قبل: _____ التأريخ: _____

تمت مراجعة هذه الوثيقة من قبل: _____ التأريخ: _____

تمت مراجعة هذه الوثيقة من قبل: _____ التأريخ: _____

ADULT PROGRAMS

Medical History Questionnaire - Adults

2012

WHEN:	Within two months after the first planned service
UPDATES:	When clinically appropriate, review at least annually.
ON WHOM:	All clients receiving services beyond two months.
COMPLETED BY:	The client or a support person. Can be also be completed by clinical staff participating in the client contact.
MODE OF COMPLETION:	Hand written on form HHSA:MHS-911 or 921 (Spanish Version).
REQUIRED ELEMENTS:	All relevant sections, both front and back.

Date of last visit to a physician: _____ Purpose of Visit: _____
Doctor's name: _____ Phone #: (____) _____
Address: _____
Name of current personal Physician: _____

Family History	**Name:**	**Age:**	If Deceased, Cause of Death	Age at Death	Has any blood relative ever had:	Encircle No or Yes	Who?
Father					Alcoholism	No Yes	
Mother					Drug Problems	No Yes	
Brother/s	1.				Depression	No Yes	
Or	2.				Mental Problems	No Yes	
Sister/s	3.				Psychiatric Treatment	No Yes	
	4.				Epilepsy	No Yes	
Spouse	5.				Neurological Disorder	No Yes	
Children	1.				Suicidal Attempts	No Yes	
	2.						
	3.						
	4.						
	5.						
Medical History	**Please place a check ✓ in front of any questions you would like to discuss in more detail with the Doctor.**						

Have you ever had:	**Circle No or Yes**
Rheumatic Fever	No Yes
Epilepsy	No Yes
Tuberculosis	No Yes
Nervousness	No Yes
Mental Problem	No Yes
Arthritis	No Yes
Bone or Joint Disease	No Yes
Meningitis	No Yes
Gonorrhea or Syphilis	No Yes
Jaundice	No Yes
Thyroid Disease	No Yes
Diabetes	No Yes
Cancer	No Yes
High Blood Pressure	No Yes
Heart Disease	No Yes
Asthma	No Yes
Stroke	No Yes

When was your last physical Examination? _____
What Medications are you allergic to?_____
Have you ever been hospitalized for any major illness? Specify: _____
_____
When and where you hospitalized: _____
Have you ever had an operation? Type and When:_____
Do you currently have any dental problems?_____
Have you had any complications from a childhood disease?_____
When was your last chest x-ray?_____
When was your last electrocardiogram?_____
What do you weigh now?_____
What was your weight one year ago?_____
What was your maximum weight and date?_____
Has Sleep been a problem?_____
Has sex been a problem?_____
Has there been a change in appetite?_____
What activities do you do for fun? _____
What time do you feel your best?_____
What physical complaints, if any do you have?_____

What medications do you take on a regular basis? _____
_____

Doctor's Notes: _____
_____
_____

County of San Diego
Health and Human Services Agency
Mental Health Services

MEDICAL HISTORY QUESTIONNAIRE

Client: _____

MR/Client ID #: _____

Program:_____

Systems History

Place a check ✓ in front of any questions that you would like to discuss in more detail with the Doctor.

Have you ever had any of the following problems

	Circle	No	Yes		Circle	No	Yes
Any eye disease injury, impaired sight		No	Yes	Night sweats		No	Yes
Any ear disease, injury, impaired hearing		No	Yes	Shortness of breath		No	Yes
Trouble with nose, sinuses, mouth or throat		No	Yes	Palpitations or fluttering heart		No	Yes
Head injuries		No	Yes	Swelling of hands, feet or ankles		No	Yes
Fainting spells		No	Yes	Back, arm or leg problem		No	Yes
Loss of Consciousness		No	Yes	Varicose veins		No	Yes
Convulsions		No	Yes	Kidney disease or stones		No	Yes
Paralysis		No	Yes	Bladder disease		No	Yes
Dizziness		No	Yes	Albumin, sugar, pus, blood in urine		No	Yes
Frequent or severe headaches		No	Yes	Difficulty in urinating		No	Yes
Depression or anxiety		No	Yes	Abnormal thirst		No	Yes
Difficulty concentrating		No	Yes	Stomach trouble or ulcer		No	Yes
Memory problems		No	Yes	Indigestion		No	Yes
Extreme tiredness or weakness		No	Yes	Appendicitis		No	Yes
Hallucinations		No	Yes	Liver or gallbladder disease		No	Yes
Enlarged glands		No	Yes	Colitis or other bowel disease		No	Yes
Enlarged thyroid or goiter		No	Yes	Hemorrhoids or rectal bleeding		No	Yes
Skin disease		No	Yes	Constipation or diarrhea		No	Yes
Chronic or frequent cough		No	Yes	Crying spells		No	Yes
Chest pain or angina pectoris		No	Yes	Suicidal thoughts		No	Yes
Coughing up blood		No	Yes	Loss of appetite		No	Yes

Habits

Do you smoke: ☐ Tobacco ☐ Cigarettes How many packs a day_____

Do you drink: ☐ Coffee ☐ Tea ☐ Cola Drinks How many cups/glasses a day_____

Do you take alcoholic beverages: ☐ Never ☐ Rarely ☐ Moderately ☐ Daily

Has alcohol use been a problem: ☐ Yes ☐ No Have you ever been treated for alcoholism: ☐ Yes ☐ No

Have you ever taken street drugs: ☐ Yes ☐ No Which drug/s:_____

During what Period:_____ How often:_____

When was the last time that you used any drug: _____

Have you ever been treated for a drug problem: ☐ Yes ☐ No When:_____

WOMEN ONLY: Menstrual History

Age at onset:_____ Cycle:_____ Days (from start to start) Date of last period:_____

Duration:_____ Days Regular: ☐ Yes ☐ No Pain or Cramps: ☐ Yes ☐ No

How many pregnancies: Miscarriages: Age of youngest living child:

Military History Not Applicable ☐

Branch_____ Rank at Discharge_____

When did you serve?_____ to_____

Type of discharge_____

Signature of Patient or Guardian_____

(Optional)

Date form Completed:_____

Doctor's Notes and Recommendations:

Physician's Signature & Date Reviewed.

County of San Diego
Health and Human Services Agency
Mental Health Services

MEDICAL HISTORY QUESTIONNAIRE

Client: _____

MR/Client ID #:_____

Program: _____

MENTAL HEALTH SERVICES

2012

ADMNISTRATIVE LEGAL

Informed Consent For Use of Psychotropic Medications

2012

WHEN: Whenever psychotropic medication is prescribed.

ON WHOM: All clients receiving psychotropic medication.

COMPLETED BY: M.D.

MODE OF COMPLETION: Legibly handwritten on HHSA:MHS-005 or HHSA:MHS-006 (Spanish Version)

REQUIRED ELEMENTS: State law defines informed consent as the voluntary consent of the client to take psychotropic medication after the physician has reviewed the following with him/her:

- Explanation of the nature of the mental problem and why psychotropic medication is being recommended.
- The general type (antipsychotic, antidepressant, etc.) of medication being prescribed and the medication's specific name.
- The dose, frequency and administration route of the medication being prescribed.
- What situations, if any, warrant taking additional medications.
- How long it is expected that the client will be taking the medication.
- Whether there are reasonable treatment alternatives.
- Documentation of "informed consent" to take psychotropic medication. A new form is to be completed:
  - When a new or different type of medication is prescribed.
  - When the client resumes taking medication following a documented withdrawal of consent.

INFORMED CONSENT FOR THE USE OF PSYCHOTROPIC MEDICATION

Client Information and Consent (Please read this form carefully and completely)

■ You have the right to be informed; be given information about your care and to ask questions.
■ You have the right to accept or reject all or any part of your care plan.
■ You have the right to revoke consent verbally or in writing to any member of the treating staff for any reason at any time.
■ You have the right to language/interpreting services. Services Requested: ☐ YES ☐ NO
■ You have the right to a copy of this Consent: Copy Requested? ☐ YES ☐ NO

Emergency Treatment: In certain emergencies, medication may be given to you when it is impractical to obtain consent. However, once the emergency has passed, medication will continue with your informed consent. *(An emergency is a temporary, sudden marked change requiring action to preserve life or prevent serious bodily harm to client or others).*

Your Physician is prescribing the following psychotropic medication(s) for you:

Medication(s) Name	Medication Info. Sheet Given (check box) ☑
	☐ YES ☐ NO
	☐ YES ☐ NO
	☐ YES ☐ NO
	☐ YES ☐ NO
	☐ YES ☐ NO
	☐ YES ☐ NO

In order to be informed and give consent, your doctor will discuss the following information with you:

Verbal Information Discussed with Client

1. Nature and seriousness of your mental illness
2. Reason(s) for medication(s) including the likelihood of improving, or not improving with or without the medication(s)
3. Reasonable alternative treatments and why doctor is recommending this particular treatment
4. Type, range of frequency and amount (including PRN orders), method (oral or injection), duration of taking medication(s)
5. Probable side effects known to commonly occur, and any particular side effects likely to occur with you
6. Possible additional side effects which may occur when taking medication(s) beyond three months
7. If prescribed a ***conventional/typical or atypical antipsychotic medication***, information will be given to you about **tardive dyskinesia,** a possible side effect caused by ***typical/atypical antipsychotic medication***. It is characterized by involuntary movements of the face or mouth and/or hands and feet. These symptoms are potentially irreversible and may appear after medication has been discontinued.

Client: _____

Case #: _____

Program: _____

Client's Consent:

Based upon the information I have read, discussed and/or reviewed with my doctor:
(check one of the following)

- ❑ I understand and give consent to the use of the psychotropic medication(s) on page one.
- ❑ I give verbal consent only; refuse to sign form.
- ❑ I do not approve/consent to the use of the psychotropic medication(s) listed below.

Please list: _____

_____
Signature of Client/Legal Rep./Guardian Date

Doctor's Statement:

I have reviewed, discussed and recommend the medication plan (page 1) for above client and:

- ❑ Client gives consent to take these medications.
- ❑ Client gives verbal consent, but unwilling or unable to sign.
- ❑ Emergency. Given medication without consent.
- ❑ Unable to understand risks and benefits, and therefore cannot consent.
- ❑ Other Comments: _____

_____

_____
Psychiatrist's Signature Date

_____
Printed Name

_____
Witness Signature (if applicable): Date

Client: _____

Case #: _____

Program: _____

CONSENTIMIENTO INFORMADO PARA EL USO DE MEDICAMENTOS PSICOTRÓPICOS

Consentimiento e información al cliente (Por favor lea todo el formulario cuidadosamente)

- Usted tiene derecho a ser informado; a que se le dé información sobre la atención que recibe y a hacer preguntas.
- Usted tiene derecho a aceptar o a rechazar todo su plan de atención, o cualquier parte del mismo.
- Usted tiene derecho a revocar su consentimiento verbalmente o por escrito a cualquier miembro del personal de tratamiento por cualquier razón y en cualquier momento.
- Usted tiene derecho a servicios de intérprete. Solicitó servicios: ☐ SÍ ☐ NO
- Usted tiene derecho a tener una copia de este Consentimiento: Solicitó copia: ☐ SÍ ☐ NO

Tratamiento de emergencia: En determinadas emergencias se le suministrarán medicamentos cuando no sea posible obtener su consentimiento. Sin embargo, una vez que la emergencia haya pasado, se continuará la administración del medicamento bajo su consentimiento informado. *(Una emergencia es un cambio notable repentino y temporal que requiere de una acción inmediata para preservar a vida o para prevenir daño corporal grave al cliente o a otras personas).*

Su médico le está recetando el/los siguiente(s) medicamento(s) psicotrópico(s):

Nombre del medicamento(s)	Se entregó página informativa del medicamento(s) (marque) ☑
	☐ SÍ ☐ NO
	☐ SÍ ☐ NO
	☐ SÍ ☐ NO
	☐ SÍ ☐ NO
	☐ SÍ ☐ NO
	☐ SÍ ☐ NO

Su médico hablará con usted sobre la siguiente información para que usted esté informado y dé su consentimiento:

Información verbal que se habló con el cliente

1. Naturaleza y gravedad de su enfermedad mental
2. Razón o razones para la administración del medicamento(s) incluyendo la posibilidad de mejorar, o de no mejorar, con o sin el medicamento(s)
3. Alternativas razonables de tratamiento y la razón por la que el médico recomienda este tratamiento en particular.
4. Tipo, frecuencia y cantidad (incluyendo órdenes de la enfermera registrada del proyecto (PRN)), método (oral o inyección), duración de la toma de medicamento(s).
5. Efectos secundarios probables que se sabe ocurren comúnmente y cualquier otro efecto secundario en particular que pudiera ocurrirle a usted.
6. Efectos adicionales posibles que pudieran ocurrir si se toma el medicamento(s) por más de tres meses.
7. Si se recetara un medicamento antipsicótico atípico o convencional/típico, se le proporcionará información acerca de la **disquinesia tardía**, un posible efecto secundario causado por medicamentos antipsicóticos típicos/atípicos. Se caracteriza por movimientos involuntarios de la cara o boca y/o de las manos y pies. Estos síntomas son potencialmente irreversibles y pueden aparecer después de que se ha descontinuado el uso del medicamento.

Consentimiento del cliente:

En base a la información que he leído, revisado y/o hablado con mi médico:
(marque uno de los siguientes)

- ❑ Yo entiendo y doy mi consentimiento para el uso del medicamento(s) psicotrópico(s) descrito en la página uno.
- ❑ Solamente doy mi consentimiento verbal; me niego a firmar el formulario.
- ❑ No doy mi aprobación/consentimiento para el uso del medicamento(s) psicotrópico(s) enumerado(s) a continuación.

Por favor enumere: _____

_____

Firma del cliente/Representante legal/Tutor Fecha

Declaración del médico:

Yo he revisado, hablado y recomendado al cliente el plan de medicamentos anterior (página 1), y:

- ❑ El cliente da su consentimiento para tomar estos medicamentos.
- ❑ El cliente da su consentimiento verbal, pero se niega o no puede firmar.
- ❑ Emergencia. Se administra el medicamento sin el consentimiento.
- ❑ No puede entender los riesgos y beneficios, y por lo tanto no puede dar su consentimiento.
- ❑ Otros comentarios:

_____

_____

_____

Firma del psiquiatra Fecha

_____

Nombre (letra de imprenta)

_____

Firma del testigo (si lo hubiera): Fecha

إتفاق إستعمال العلاج النفسي

معلومات العميل و قبوله بشروط الإتفاق (الرجاء مراجعة هذه الإستمارة بدقة و بشكل كامل)

- لديك حق الإطلاع على المعلومات المتعلقة بعلاجك و حق طرح أي أسئلة تتعلق بذلك.
- لديك الحق بقبول أو رفض أي جزء من خطة علاجك.
- لديك الحق بإلغاء هذا الإتفاق شفهياً أو تحريرياً و ذلك عن طريق إبلاغ أي من أعضاء الفريق المشرف على علاجك و ذلك لأي سبب كان و في أي وقت تختاره.
- لديك حق الحصول على خدمات الترجمة بلغتك الأم. هل ترغب بالحصول على خدمات الترجمة؟ ☐ **نعم** ☐ **لا**
- لديك الحق بالحصول على نسخة من هذا الإتفاق. هل ترغب بالحصول على نسخة من هذا الإتفاق؟ ☐ **نعم** ☐ **لا**

العلاج في الحالات الطارئة: في بعض الحالات الطارئة، قد يتم إعطائك دواءاً (عقاراً) معيناً عندما يكون من غير الممكن الحصول على موافقتك على ذلك. لكن بعد تجاوز الحالة الطارئة، سيستمر إستخدام الدواء (العقار) فقط بعد موافقتك على ذلك. (*الحالة الطارئة هي حالة مؤقتة، يصاحبها تغير مفاجئ يتطلب فعل ما لحماية إستمرارية الحياة أو منع حصول أذى خطير لجسد العميل أو الأخرين*).

يصف طبيبك الأدوية (العقاقير) التالية لك:

إسم الدواء (العقار)	بيانات الدواء (العقار). هل تم إعطاءك بيانات الدواء (العقار) (إختر المربع المناسب) ☑
	☐ **نعم** ☐ **لا**
	☐ **نعم** ☐ **لا**
	☐ **نعم** ☐ **لا**
	☐ **نعم** ☐ **لا**
	☐ **نعم** ☐ **لا**
	☐ **نعم** ☐ **لا**

من أجل أن يتم إطلاعك على المعلومات و الحصول على موافقتك، سيقوم طبيبك بمناقشة المعلومات الواردة أدناه معك:

المعلومات التي سيتم مناقشتها مع العميل شفهياً

1. طبيعة و خطورة مرضك النفسي
2. الأسباب التي تستدعي أخذك للدواء (العقار) و بضمنها إحتمالية تحسن حالتك أو عدم تحسنها عند أخذ أو عدم أخذ الدواء (العقار)
3. دواء (عقار) بديل منطقي و سبب إختيار الطبيب لهذا الدواء (العقار) بالذات
4. نوع و عدد مرات إستخدام و كمية (بضمنها الدواء الذي يؤخذ عند الحاجة فقط) و طرق (سواء كان عن طريق الفم أو الحقن) و الفترة التي يجب خلالها أخذ الدواء (العقار)
5. الأعراض الجانبية المحتمل حدوثها، و أي أعراض جانبية يمكن أن تتعرض لها
6. الأعراض الجانبية المحتمل حدوثها عند إستخدام الدواء (العقار) لأكثر من ثلاثة أشهر
7. إن تم وصف دواء (عقار) إعتيادي أو غير إعتيادي للذهان (الهذيان)، سيتم إطلاعك على بينات حالة Tardive Dyskinesia و هي عرض جانبي محتمل عند إستخدام الدواء (العقار) الإعتيادي أو الغير الإعتيادي للذهان. يمكن تشخيص أعراض هذه الحالة بالحركات اللاإرادية لعضلات الوجه و الفم و/أو اليدين و القدمين. عادةً، ليس بالمستطاع التخلص من هذه الأعراض و قد تستمر بالحصول حتى بعد توقفك عن أخذ الدواء (العقار).

موافقة العميل

بناءاً على المعلومات التي قرأتها و/أو قمت بمناقشتها و/أو مراجعتها مع طبيبي:
(حدد خياراً واحداً من الخيارات التالية)

- ❑ إني أقر و أوافق على إستخدام الأدوية (العقاقير) الواردة في الصفحة رقم 1 من هذه الإستمارة.
- ❑ أمنح موافقتي الشفهية فقط، و أرفض توقيع هذه الإستمارة.
- ❑ لا أوافق على إستخدام الأدوية (العقاقير) المذكورة أدناه.

الرجاء ذكر أسماء الأدوية (العقاقير) _____

_____

توقيع العميل/الممثل القانوني/الوصي التأريخ

بيان الطبيب

لقد قمت بمراجعة و مناقشة و نصح العميل المذكور أعلاه بخطة العلاج الواردة في الصفحة رقم 1 من هذه الإستمارة و:

- ❑ وافق العميل على أخذ هذه الأدوية (العقاقير)
- ❑ وافق العميل شفهياً على أخذ هذه الأدوية (العقاقير)، إلا إنه غير راغب أو غير قادر على توقيع هذه الإستمارة.
- ❑ الحالة طارئة، و تم إعطاء العلاج للعميل دون موافقته.
- ❑ لم يكن العميل قادراً على تفهم المخاطر و الفوائد و لذلك لا يستطيع الموافقة.
- ❑ تعليقات أخرى: _____

_____

_____ _____

توقيع الطبيب النفسي التأريخ

_____

الإسم (يكتب بشكل واضح)

_____ _____

توقيع الشاهد (إن وجدت الحاجة إليه) التأريخ

THÔNG TIN VỀ VIỆC ĐỒNG Ý DÙNG THUỐC CÓ ẢNH HƯỞNG TÂM THẦN

Tài liệu về thân chủ và Sự Đồng Ý (Consent).

Bạn có quyền được biết, được thông báo và được quyền hỏi cho rõ về việc chữa trị cuả bạn.

Bạn có quyền chấp nhận hay chối bỏ tất cả hay một phần trong chương trình chữa trị cho bạn.

Bạn có quyền rút lại sự đồng ý bằng lời nói hay viết đơn tới bất cứ nhân viên chữa trị bất cứ lúc nào và vì bất cứ lý do gì.

Bạn có quyền xin dịch vụ thông dịch. Bạn có cần không: ☐ CÓ ☐ KHÔNG

Bạn có quyền giữ một bản sao của tờ Đồng ý này: Bạn có muốn không? ☐ CÓ ☐ KHÔNG

Chữa Trị Khẩn Cấp: Trong một số trường hợp khẩn cấp , bạn được dùng thuốc dù không thể lấy bản đồng ý. Tuy nhiên, khi khẩn cấp đã qua, thuốc sẽ được cung cấp với sự đồng ý cuả bạn *(Khẩn cấp là một lúc cấp thời, sự việc xẩy ra đòi hỏi hành động phải làm để duy trì mạng sống và tránh thương tích cho bệnh nhân và cho các người khác).*

Bác sĩ cuả bạn đã kê các thuốc có tác dụng tâm thần sau nay cho bạn:

Tên Thuốc	Tên Thuốc

Để hiểu rõ và đồng ý,bác sĩ của bạn sẽ bàn về các dữ kiện sau nay với bạn:

Các điều đã thảo luận bằng lời nói với thân chủ

1. Bệnh trạng nặng nhẹ về tâm thần của bạn
2. Lý do dùng thuốc, kể cả cơ hội sẽ bớt bệnh, hay không bớt, cho dù có thuốc hay không.
3. Các cách chữ trị khác và lý do bác sĩ chọn cách chữa trị này
4. Loại, tính thường xuyên, số lượng (kể cả toa PRN), Phương thức (chích hoặc uống), thời gian dùng thuốc bao lâu .
5. Các phản ứng phụ thường xảy ra, và bất cứ các phản ứng phụ có thể xẩy ra cho bạn.
6. Các phản ứng phụ có thể xảy ra khi dùng thuốc lâu hơn ba tháng.
7. Nếu kê toa loại thuốc ***theo quy ước/thông thường hay không thông thường chống rối loạn tâm thần,*** dũ kiện sẽ cung cấp cho bạn về **tardive dyskinesia,** một phản ứng phụ có thể xẩy ra bởi ***thuốc chữa trị thông thường hay không thông thường*** . Phản ứng này gây ra việc tự nhiên rung bắp thịt mặt, miệng và/hoặc tay chân. Những triệu chứng này có thể không trở lại bình thường và có thể xẩy ra sau khi đã ngừng thuốc.

Client: _____

MR/Client ID #: _____

Program: _____

Sự Đồng Ý của Bệnh Nhân:

Sau khi đã đọc những thông tin trên, bàn thảo và coi lại với bác sĩ của tôi :
(chọn một trong những câu dưới đây)

- ❑ Tôi hiểu và đồng ý dùng các thuốc có ảnh hưởng tâm thần ở trang 1.
- ❑ Tôi đồng ý bằng lời nói mà thôi; từ chối ký tên vào mẫu.

Tôi không chấp thuận/đồng ý để dùng các thuốc thuốc có ảnh hưởng tâm thần sau đây:

Xin kể ra: _____

_____

Chữ kýcủa khách hàng/Đại diện pháp lý/Người giám hộ Ngày

Lời Ghi của Bác Sĩ:

Tôi đã coi lại, bàn thảo và đề nghị thuốc chữa trị (Trang 1) cho bệnh nhân nói trên và:

- ❑ Bệnh nhân đồng ý dùng các thuốc .
- ❑ Bệnh nhân đồng ý bằng lời nói; nhưng không muốn ký tên vào mẫu
- ❑ Khẩn cấp, Cho dùng thuốc không có sự đồng ý.
- ❑ Không hiểu sự nguy hiểm và phúc lợi của thuốc, do đó không thể đồng ý.
- ❑ Ghi chú thêm: _____

_____

_____

Chữ ký bác sĩ tâm thần: Ngày

_____

Viết tên

_____

Chữ ký nhân chứng (nếu có): Ngày

ADVANCE DIRECTIVE ADVISEMENT - PAPER

2012

WHEN:	Provide clients with written information concerning their rights under federal and state law regarding Advance Medical Directives at the first face to face contact (or when legally required based on age or emancipation status) for services and thereafter upon request by the beneficiary. Federal regulations put this into effect as of June 1, 2004.
ON WHOM:	All new adult clients and emancipated minors.
COMPLETED BY:	Any program staff member who provided the written instruction.
MODE OF COMPLETION:	Legibly handwritten on Advance Directive Advisement form (MHS-611).
REQUIRED ELEMENTS:	Check appropriate box to reflect if client has been informed of right to have an Advance Directive (AD); if AD brochure was offered; if client has an executed AD; and when applicable if AD has been placed in medical record when provided by the client. Check box to indicate if client has been informed that complaints concerning noncompliance with AD requirements may be filed with the California Department of Health Services, Licensing and Certification Division at P.O. Box 997413, Sacramento, CA 95899-1413 or by calling 1-800-236-9747. Inform client of right to have AD placed in Medical Record. Staff member who advises client of AD shall sign and date the form. T Bar shall include the client's name, case number, and program name.

ADVANCE DIRECTIVE ADVISEMENT

Code of Federal Regulations (CFR) Chapter IV, Part 489.100 defines Advance Directives as: "a written instruction, such as living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated."

CRF Section 422.128 requires that all "M+C organizations" maintain written policies and procedures to meet the requirements of informing all adult individuals and emancipated minors receiving medical care by or through the M+C organization about advance directives. This information must reflect consequent changes in State law, no later than 90 days after the effective date of the State law.

As of June 1, 2004 Federal Regulations requires that all NEW adult clients (18 years and older) and emancipated minors be informed of their right to have an Advance Directive (AD). Therefore all clients who turn 18 or become emancipated after June 1, 2004 shall be informed of their right to have an AD. This physical health AD allows the individual to outline the kind of healthcare treatment they want, and who can speak on their behalf when they are not able to communicate their wishes. See County of San Diego Advance Directives Policy and Procedure Number 01-01-130.

Informed client of right to have an Advance Directive: ☐Yes ☐No

Offered Advance Directive Brochure: ☐Yes ☐No

Client has been informed that complaints concerning noncompliance with AD requirements may be filed with: California Department of Health Services
Licensing and Certification Division ☐Yes ☐No
P.O. Box 997413
Sacramento, CA 95899-1413
1-800-236-9747

Does client have an executed Advance Directive: ☐Yes ☐No ☐Client did not disclose

Informed client of right to have AD placed in medical record: ☐Yes ☐No
Provided AD shall be attached to this form and placed in client's medical record in Medical Section.

Staff Signature: _____ Date: _____

REQUEST FOR ACCESS AND/OR COPY OF PROTECTED HEALTH INFORMATION
(County Providers)

WHEN: Upon request for access and/or copy of medical record or excerpts from medical record.

ON WHOM: All Mental Health Clients.

COMPLETED BY: Client and/or guardian.

MODE OF COMPLETION: Legibly handwritten or typed on 23-01 HHSA (04/03).

REQUIRED ELEMENTS:

- Date.
- Client information to include last name, first name, middle initial, address, city/state, zip code, any AKA's, telephone number, SSN (optional), and DOB.
- Representative information, when client/guardian wishes to have information given to another person or entity.
- Check or listing of information that is being requested.
- Beginning and end date of search.
- Where and how information is being requested (in person, mail, specific location).
- Signature and date of client and/or legal guardian submitting request.
- Staff member processing the request shall sign and date form as well as complete T Bar information to include the client's name, Case number, and program name.

Individual who consents to treatment may submit request. Clients who are 18 years of age or older or emancipated may submit their own request. Additionally, under some circumstances a minor 12 years and older may submit their own request (see Welfare and Institutions Code 14010 and Family Code 6924, 6929, 7050).

Day Programs provide an all-inclusive rate and shall capture the billing of all clients enrolled in their program on a given day utilizing their own program's billing record.

NOTE: This is a county form for county providers. Contracted providers are to seek their own legal counsel. Form available on County Internet.

COUNTY OF SAN DIEGO

REQUEST FOR ACCESS AND/OR COPY OF PROTECTED HEALTH INFORMATION

You have the right to request to review your personal health information we create or maintain. You also have the right to request copies of those records for which you will be charged $.15 per page. Within five (5) business days after we receive your request to access your record, one of our staff will contact you to set an appointment for you to review your records or we will inform you in writing that we have denied your request for access and state the reason why. After you have completed this form, you need to mail or return it to:

SAN DIEGO COUNTY MENTAL HEALTH
P.O. BOX 85524
SAN DIEGO, CA 92186-5524
(619) 692-5700 EXT 3

DATE:

PATIENT/RESIDENT/CLIENT		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS	CITY/STATE:	ZIP CODE:
AKA'S		
TELEPHONE NUMBER:	SSN:	DATE OF BIRTH:

County of San Diego

REQUEST FOR ACCESS AND/OR COPY OF PROTECTED HEALTH INFORMATION

Client: _____

Record Number: _____

Program: _____

REPRESENTATIVE INFORMATION

(Complete only if you want us to give your information to another person or entity.)

I authorize the following person to receive the requested information.

LAST NAME OR ENTITY:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS	CITY/STATE:	ZIP CODE:
RELATIONSHIP:		TELEPHONE NUMBER:

PERSONAL HEALTH INFORMATION TO WHICH YOU WANT ACCESS

- ☐ History and Physical Examination
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Medication Records
- ☐ Interpretation of images: x-rays, sonograms, etc.
- ☐ Laboratory results
- ☐ Dental records
- ☐ Psychiatric records including Consultations
- ☐ HIV/AIDS blood test results; any/all references to those results
- ☐ Physician Orders
- ☐ Pharmacy records
- ☐ Immunization Records
- ☐ Nursing Notes
- ☐ Billing records
- ☐ Drug/Alcohol Rehabilitation Records
- ☐ Complete Record
- ☐ Other *(Provide description)* _____ _____ _____

From what dates do you want information *(period of time)*

Date to begin search:	Date to end search:

County of San Diego

REQUEST FOR ACCESS AND/OR COPY OF PROTECTED HEALTH INFORMATION

Client: _____

Record Number: _____

Program: _____

ACCESS METHOD AND LOCATION	
Where and when do you want to inspect or receive copies of your information:	
IN PERSON: ☐ YES	LOCATION:
COPIES BY MAIL: ☐ YES	

YOUR SIGNATURE	
SIGNATURE:	DATE:

FOR OFFICE USE

VALIDATION	
SIGNATURE OF STAFF PERSON VALIDATING INFORMATION:	DATE:
SIGNATURE OF HEALTH CARE PROVIDER*:	DATE:

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION
(County Providers)

2012

WHEN: Completed to request information from other parties, and/or when releasing information.

ON WHOM: All clients for whom exchange of information with another party is warranted.

Applicable State and federal law allows for exchange of information between health care providers for the purpose of treatment and payment. Additionally, see DMH Information Notice No.: 04-07 for change in confidentiality of Mental Health Information.

COMPLETED BY: Staff member who identifies need to request or exchange information on behalf of the client.

MODE OF COMPLETION: Legibly handwritten or typed on 23-07 HHSA (04/03) form.

REQUIRED ELEMENTS:

- Current date.
- Client information which includes: last name, first name, middle initial, address, city/state, zip code, telephone number, SSN (optional), DOB, and any AKA's.
- Individual or organization authorized to make disclosure.
- Individual or organization to whom the information may be disclosed to and used by.
- Type of information to be disclosed.
- Expiration date, event or condition (when not specified authorization shall expire in one calendar year from the date it was signed).
- Signature of client or legal representative/guardian with date.
- Validation of form with signature and date of provider is optional.
- T Bar shall include client's name, InSyst number, and program name.

Individual who consents to treatment is responsible for authorizations. Clients who are 18 years of age or older or emancipated may sign for their own authorization. Additionally, under some circumstances a minor 12 years and older may sign for authorization (see Welfare and Institutions Code 14010 and Family Code 6924, 6929, 7050).

.

DEPENDENTS & WARDS:

An ex-parte or court order may be utilized to authorize use or disclosure of protected health information.

Authorization to Use or Disclose Protected Health Information – Parent (number 04-24A-P and dated 03/04) is generated by the Child Welfare Services worker for the parent / guardian to sign for the purpose of disclosing protected health information to the Child Welfare Services worker.

Order for Release of Protected Health and Education Information (number 04-24A-C and dated 04/04) is generated by the Courts for the purpose of disclosing protected health information to the Child Welfare Services worker.

SCHOOL:

Authorization for Use or Disclosure of Health Information to School Districts. Dated 10/20/03. May be used for exchange of information with the school.

NOTE:

This is a county form for county providers. Contracted providers are to seek their own legal counsel regarding authorization and appropriate forms.

Assembly Bill No. 715 that was filed with Secretary of State September 29, 2003 requires that authorizations be printed in 14-point type.

Authorization as written is one-directional, allowing the authorized party to disclose information to the party designated to receive the information.

HIPAA forms in threshold languages are available through the County Internet. From the County Website go to: depart/employees, dept/program home pages, Select H (from alpha list), Health and Human Services Agency, Documents, Forms, scroll down and you will see a multitude of HIPAA forms.

COUNTY OF SAN DIEGO
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize use or disclosure of the named individual's health information as described below.

		DATE:
PATIENT/CLIENT/ FACILITY RESIDENT		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
TELEPHONE NUMBER:	SSN (OPTIONAL):	DATE OF BIRTH:
AKA'S:		
THE FOLLOWING IS AUTHORIZED TO MAKE THE DISCLOSURE.		
NAME OR ENTITY:		
ADDRESS AND TELEPHONE NUMBER:		
THIS INFORMATION MAY BE DISCLOSED TO AND USED BY THE FOLLOWING.		
NAME OR ORGANIZATION:		
ADDRESS AND TELEPHONE NUMBER:		
TREATMENT DATES:	PURPOSE OF REQUEST: ☐ AT THE REQUEST OF THE INDIVIDUAL.	

THE FOLLOWING INFORMATION IS TO BE DISCLOSED: (PLEASE CHECK)

- ☐ History and Physical Examination
- ☐ Discharge Summary
- ☐ Progress Notes
- ☐ Medication Records
- ☐ Interpretation of images: x-rays, sonograms, etc.
- ☐ Laboratory results
- ☐ Dental records
- ☐ Psychiatric records including Consultations
- ☐ HIV/AIDS blood test results; any/all references to those results
- ☐ Physician Orders
- ☐ Pharmacy records
- ☐ Immunization Records
- ☐ Nursing Notes
- ☐ Billing records
- ☐ Drug/Alcohol Rehabilitation Records
- ☐ Complete Record
- ☐ Other *(Provide description)* _____

Patient/Client/Facility Resident or their Legal Representative's Initials: _____

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____.
If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied.

I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section164.524.

I have the right to receive a copy of this authorization. I would like a copy of this authorization. ☐ Yes ☐ No

SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE	
SIGNATURE:	DATE:
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP OF INDIVIDUAL:	

FOR OFFICE USE

Please verify that the patient/client/facility resident or their legal representative has initialed each page of this authorization.

VALIDATE IDENTIFICATION ☐	
SIGNATURE OF STAFF PERSON:	DATE:

MENTAL HEALTH SERVICES

2012

CHILDREN'S PROGRAMS

CONSENT FOR MENTAL HEALTH SERVICES - Child
(County Providers)

2012

WHEN:	Upon initial registration to Mental Health System and annually from date of initial registration.
ON WHOM:	All Mental Health Clients.
COMPLETED BY:	Any program staff member who reviews the parameters of consent.
MODE OF COMPLETION:	Legibly handwritten on Consent for Mental Health Services form (MHS-272).
REQUIRED ELEMENTS:	Outline child's full name for which the consent is being obtained. Client and/or Parent/Legal Guardian signature with date. Clients who are 18 years of age or older or emancipated may consent for their own treatment. Additionally, under some circumstances a minor 12 years and older may consent for their own treatment (see Welfare and Institutions Code 14010 and Family Code 6924, 6929, 7050). T Bar shall include client's name, Case number, and program name.
DEPENDENTS & WARDS:	An ex-parte or court order may be utilized to authorize mental health treatment, as well as a form titled Consent for Treatment – Parent (number 04-24P and dated 06/03) which is generated by the Child Welfare Services worker for the parent / guardian to sign.
NOTE:	This is a county form for county providers. Contracted providers are to seek their own legal counsel regarding consent for treatment and appropriate forms.

Consent For Mental Health Services

This is to authorize San Diego County Children's Mental Health Services to evaluate and or treat
Child's Name: _____

The conditions of the treatment have been explained to me to my satisfaction. I understand that records concerning treatment will be retained. Such data will be kept confidential according to all applicable State and federal laws.

Law compels the County of San Diego, Children's Mental Health Staff, to take action to protect you by informing appropriate person(s) and/or to inform the other person(s) if we believe you are in imminent danger of causing serious harm to yourself or another person(s). Additionally, we are mandated to report any reasonable suspicion that a child, dependent adult, and/or elderly adult have been abused. See Notice of Privacy Practices for complete outline of allowable disclosures.

I have read the above or had it read or explained to me, understand content, and agree to the conditions. I understand that I can withdraw my consent and terminate from this program and its services at any time. This consent will expire upon termination of your current treatment.

Client Signature: _____

Parent/Legal Guardian Signature: _____

Date: _____

Client: _____

InSyst #: _____

Program: _____

CONSENTIMIENTO PARA RECIBIR SERVICIOS DE SALUD MENTAL

Este documento tiene como propósito autorizar a San Diego County Children's Mental Health Services (Servicios de salud mental para niños del condado de San Diego) para evaluar o dar tratamiento a:

Nombre del niño(a): _____

Se me han explicado las condiciones del tratamiento a mi satisfacción. Entiendo que los expedientes relacionados con el tratamiento serán conservados por la institución. Dicha información se mantendrá confidencial de acuerdo a las leyes federales y estatales correspondientes.

La ley obliga al personal de salud mental para niños del Condado de San Diego a tomar acción para protegerlo a usted al informar a la persona(s) adecuada(s) y/o para informar a la otra persona(s), si nosotros creemos que usted está en peligro inminente de ocasionarse daños graves a sí mismo o a otra persona(s). Además, se nos ordena reportar cualquier sospecha razonable de que un niño(a), adulto dependiente, y/o anciano ha sufrido abuso. Vea la Notificación sobre Prácticas Privadas para completar el resumen de las divulgaciones permitidas.

He leído lo anterior, o me ha sido leído o explicado, entiendo su contenido y estoy de acuerdo con las condiciones. Entiendo que puedo retirar mi consentimiento y terminar con este programa y sus servicios en cualquier momento. Este consentimiento se vencerá al término del tratamiento actual.

Firma del cliente: _____

Firma del padre/madre/tutor legal: _____

Fecha: _____

Client: _____

InSyst #: _____

Program: _____

إتفاقية خدمات الصحة النفسية

تخول هذه الوثيقة مقاطعة سان دييغو، قسم خدمات الصحة النفسية الخاصة بالقاصرين بالقيام بتقييم أو علاج الطفل المدعو: _____

لقد شرحت لي شروط العلاج وصولاً الى إقتناعي بها. إنني أعلم بإنه سيتم الإحتفاظ بالوثائق المتعلقة بالعلاج. سيتم الإحتفاظ بخصوصية تلك البيانات طبقاً للقانون الإتحادي (الفدرالي) و قوانين الولاية.

يفرض القانون على مقاطعة سان دييغو، كادر عمل خدمات الصحة النفسية الخاصة بالقاصرين، أن يقوموا بأخذ الإجراءات اللازمة لحمايتك و ذلك بإطلاع الأشخاص المناسبين و/أو أطلاع الأشخاص الأخرين إذا إعتقدنا أن هنالك إحتمال جدي بإنك ستقوم بإيذاء نفسك أو بإيذاء الأخرين. بالإضافة لذلك، فإننا ملزمون بالإبلاغ عن أي شك منطقي بحصول إستغلال لطفل، أو شخص بالغ معتمد على الأخرين أو شخص مسن. يرجى مراجعة بيان سياسة الخصوصية للحصول على لائحة كاملة بعمليات تداول المعلومات المسموح بها.

لقد قَرأتُ أو قُرأتْ أو شرحت لي الإتفاقية الواردة أعلاه و لقد إستوعبت محتواها و وافقت على شروطها. إنني أعلم بإنه يمكني سحب موافقتي و إلغاء إشتراكي في هذا البرنامج و خدماته في أي وقت. سينتهي العمل في هذا الإتفاقية عند نهاية مرحلة علاجك الحالية.

توقيع العميل: _____

توقيع أحد الوالدين أو الوصي القانوني: _____

التأريخ: _____

Mẫu Thoả Thuận Chấp Nhận Chữa Trị Bệnh Tinh Thần

Tôi cho phép Sở Chăm Sóc Tâm Thần Trẻ Em Quận Hạt San Diego (San Diego County Children's Mental Health Services) định bệnh và chữa trị cho Em (tên) : _____

Tôi bằng lòng với các điều kiện chữa trị được giải thích cho tôi. Tôi hiểu rằng hồ sơ chữa trị sẽ được lưu giữ lại. Những chi tiết trong hồ sơ sẽ được giữ kín theo đúng luật của Tiểu Bang và Liên Bang.

Luật bắt buộc Sở Chăm Sóc Tâm Thần Trẻ Em Quận Hạt San Diego phải có hành động để bảo vệ bạn bằng cách báo tin cho những người liên quan, hoặc những người mà chúng tôi tin rằng sẽ có hành động nguy hiểm cho bạn hoặc cho người khác. Hơn nữa chúng tôi cũng bị bắt buộc phải báo cáo khi có nghi ngờ về việc một trẻ em, người thân thuộc, hoặc người già bị ngược đãi. Xin tham khảo phần ghi chú về Cách Bảo Vệ Bí Mật Cá Nhân (Notice of Privacy Practices) để hiểu rõ phạm vi chúng tôi được tiết lộ.

Tôi đã đọc, hoặc có người đọc cho tôi nghe hoặc giải nghĩa cho tôi, và tôi đồng ý với các điều kiện trên. Tôi hiểu rằng tôi có thể rút lại sự thoả thuận này và chấm dứt tham gia chương trình và các dịch vụ liên hệ bất cứ lúc nào. Sự thoả thuận này sẽ hết hiệu lực khi thời gian chữa trị này chấm dứt.

Bệnh nhân ký tên: _____

Phụ Huynh/Người giám hộ ký tên _____

Ngày: _____

ADULT PROGRAMS

Agreement For Services – Adult
(County Form)

2012

WHEN: First Face to Face Contact

ON WHOM: All clients

COMPLETED BY: Client and the staff member registering the client

MODE OF COMPLETION: Legibly handwritten on form HHSA-MHS-119

REQUIRED ELEMENTS: All

I, _____ agree to accept clinical treatment at
Client's Name

_____
Name of Clinic

The clinical treatment will include, but may not be limited to: intake assessments, designations of a primary therapist, as well as individual therapy, and medication monitoring. Psychiatric evaluation and medications are also available as needed. Signing this document implies agreement to all sections of the contract including sections on appointments, confidentiality, fee (if any), and rules and regulations.

CONTRACT GUIDELINES FOR SERVICES

1. Appointments: Your appointment time is specifically reserved for you. Because your appointment is reserved only for you, it is *necessary* that you not miss any appointments. Please *call at least 24 hours in advance to cancel appointments. If you miss more than two appointments, it will be discussed with you and your therapist, or doctor, and could mean that you will be discharged from the clinic. Remember, both your time and your therapist's time are very important.*

2. Length of treatment at the clinic may be limited and may consist of as few as 1-8 visits. Please discuss your expectations with your therapist and come to a preliminary agreement.

3. Confidentiality: All patients are assured of confidentiality in psychotherapy. A release of information form signed by you may authorize us to discuss any information with other individuals, and this agreement may be revoked by you at any time. There are some exceptions to confidentiality including:

    a. The law requires that we notify the potential victim if we judge that a client has the intention to harm another individual.

    b. We are required by law to report any suspected child abuse, neglect, or molestation to protect minors. Similarly, we are required to report suspected cases of elder abuse.

    c. If we judge the client to be seriously suicidal or unable to care for himself, we are obliged to notify the authorities to arrange for hospitalization.

    d. When you use health insurance to pay for psychotherapy, you may have to waive your confidentiality between insurance companies, officials, and your therapist.

I have read, understand and agree to accept treatment at the above named Clinic.

_____ _____
Client Signature Today's Date

_____ _____
Witness Today's Date

County of San Diego
Health and Human Services Agency
Mental Health Services

AGREEMENT FOR SERVICES

Client:_____

MR/Client ID #:_____

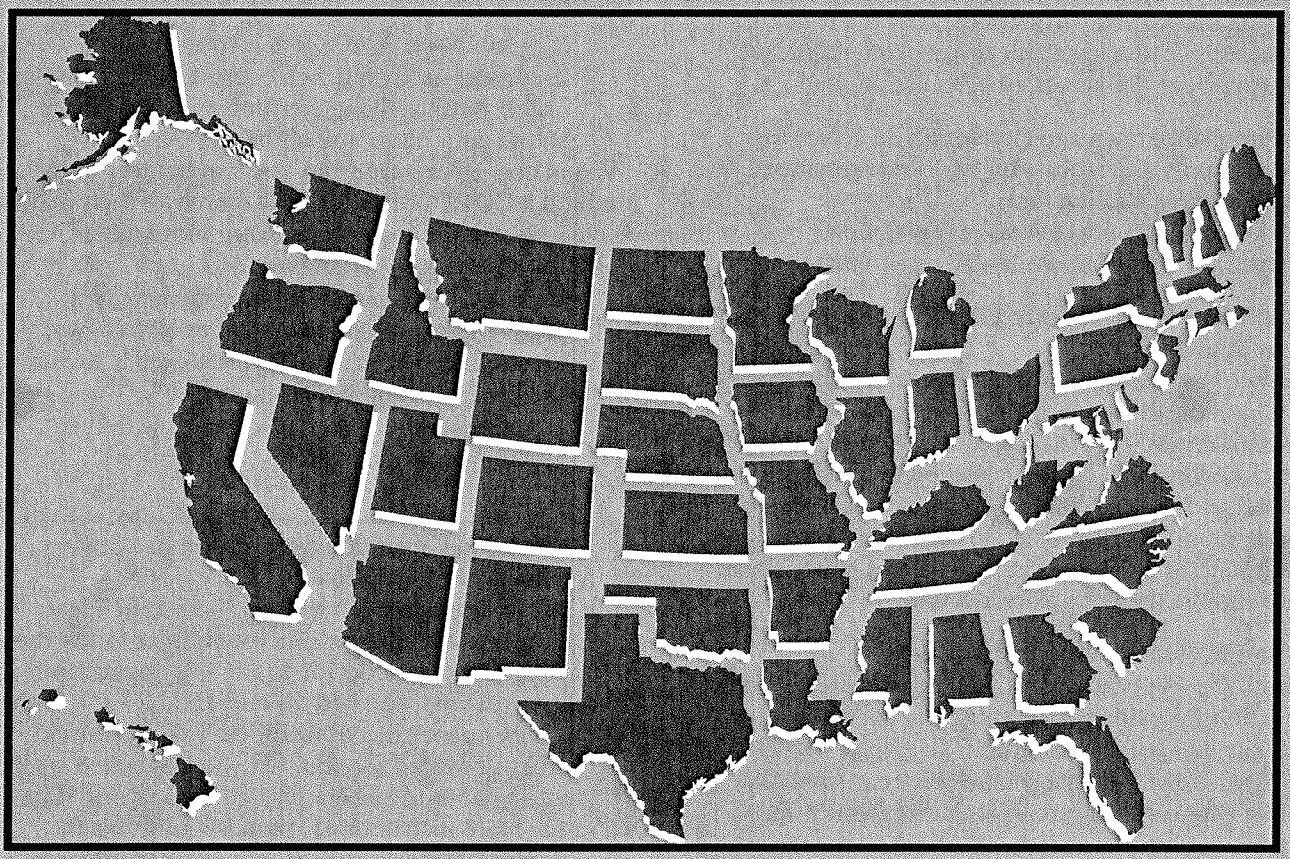
Program:_____

MENTAL HEALTH SERVICES

2012

VOTER REGISTRATION

Register To Vote In Your State By Using This Postcard Form and Guide



For U.S. Citizens

General Instructions

Who Can Use this Application
If you are a U.S. citizen who lives or has an address within the United States, you can use the application in this booklet to:

- Register to vote in your State,
- Report a change of name to your voter registration office,
- Report a change of address to your voter registration office, or
- Register with a political party.

Exceptions
Please do not use this application if you live outside the United States and its territories and have no home (legal) address in this country, *or* if you are in the military stationed away from home. Use the Federal Postcard Application available to you from military bases, American embassies, or consular offices.

New Hampshire town and city clerks will accept this application only as a request for their own absentee voter mail-in registration form.
North Dakota does not have voter registration.
Wyoming law does not permit mail registration.

How to Find Out If You Are Eligible to Register to Vote in Your State
Each State has its own laws about who may register and vote. Check the information under your State in the State Instructions. All States require that you be a United States citizen by birth or naturalization to register to vote in federal and State elections. Federal law makes it illegal to falsely claim U.S. citizenship to register to vote in any federal, State, or local election. You **cannot** be registered to vote in more than one place at a time.

How to Fill Out this Application
Use both the Application Instructions and State Instructions to guide you in filling out the application.

- First, read the Application Instructions. These instructions will give you important information that applies to everyone using this application.
- Next, find your State under the State Instructions. Use these instructions to fill out Boxes 6, 7, and 8. Also refer to these instructions for information about voter eligibility and any oath required for Box 9.

When to Register to Vote
Each State has its own deadline for registering to vote. Check the deadline for your State on the last page of this booklet.

How to Submit Your Application
Mail your application to the address listed under your State in the State Instructions. Or, deliver the application in person to your local voter registration office. The States that are required to accept the national form will accept copies of the application printed from the computer image on regular paper stock, signed by the applicant, and mailed in an envelope with the correct postage.

First Time Voters Who Register by Mail
If you are registering to vote for the first time in your jurisdiction and are mailing this registration application, Federal law requires you to show proof of identification the first time you vote. Proof of identification includes:

- A current and valid photo identification or
- A current utility bill, bank statement, government check, paycheck or government document that shows your name and address.

Voters may be exempt from this requirement if they submit a **COPY** of this identification with their mail in voter registration form. If you wish to submit a **COPY**, please keep the following in mind:

- Your state may have additional identification requirements which may mandate you show identification at the polling place even if you meet the Federal proof of identification.
- Do not submit original documents with this application, only **COPIES.**

If You Were Given this Application in a State Agency or Public Office
If you have been given this application in a State agency or public office, it is your choice to use the application. If you decide to use this application to register to vote, you can fill it out and leave it with the State agency or public office. The application will be submitted for you. Or, you can take it with you to mail to the address listed under your State in the State Instructions. You also may take it with you to deliver in person to your local voter registration office.
Note: The name and location of the State agency or public office where you received the application will remain confidential. It will not appear on your application. Also, if you decide not to use this application to register to vote, that decision will remain confidential. It will not affect the service you receive from the agency or office.

Application Instructions

Before filling out the body of the form, please answer the questions on the top of the form as to whether you are a United States citizen and whether you will be 18 years old on or before Election Day. If you answer no to either of these questions, you may not use this form to register to vote. However, state specific instructions may provide additional information on eligibility to register to vote prior to age 18.

Box 1 — Name
Put in this box your full name in this order — Last, First, Middle. Do not use nicknames or initials.
Note: If this application is for a change of name, please tell us in **Box A** *(on the bottom half of the form)* your full name before you changed it.

Box 2 — Home Address
Put in this box your home address (legal address). Do **not** put your mailing address here if it is different from your home address. Do **not** use a post office box or rural route without a box number. Refer to state-specific instructions for rules regarding use of route numbers.

Note: If you were registered before *but* this is the first time you are registering from the address in Box 2, please tell us in **Box B** *(on the bottom half of the form)* the address where you were registered before. Please give us as much of the address as you can remember.

Also Note: If you live in a rural area but do not have a street address, *or* if you have no address, please show where you live using the map in **Box C** *(at the bottom of the form).*

Box 3 — Mailing Address
If you get your mail at an address that is different from the address in Box 2, put your mailing address in this box. If you have no address in Box 2, you **must** write in Box 3 an address where you can be reached by mail.

Box 4 — Date of Birth
Put in this box your date of birth in this order — Month, Day, Year. *Be careful not to use today's date!*

Box 5 — Telephone Number
Most States ask for your telephone number in case there are questions about your application. However, you do **not** have to fill in this box.

Box 6 — ID Number
Federal law requires that states collect from each registrant an identification number. You must refer to your state's specific instructions for item 6 regarding information on what number is acceptable for your state. If you have neither a drivers license nor a social security number, please indicate this on the form and a number will be assigned to you by your state.

Box 7 — Choice of Party
In some States, you must register with a party if you want to take part in that party's primary election, caucus, or convention. To find out if your State requires this, see item 7 in the instructions under your State.

If you want to register with a party, print in the box the full name of the party of your choice.

If you do **not** want to register with a party, write "no party" or leave the box blank. Do **not** write in the word "independent" if you mean "no party," because this might be confused with the name of a political party in your State.
Note: If you do not register with a party, you can still vote in general elections and nonpartisan (nonparty) primary elections.

Box 8 — Race or Ethnic Group
A few States ask for your race or ethnic group, in order to administer the Federal Voting Rights Act. To find out if your State asks for this information, see item 8 in the instructions under your State. If so, put in Box 8 the choice that best describes you from the list below:

- American Indian *or* Alaskan Native
- Asian or Pacific Islander
- Black, *not of* Hispanic Origin
- Hispanic
- Multi-racial
- White, *not of* Hispanic Origin
- Other

Box 9 — Signature
Review the information in item 9 in the instructions under your State. Before you sign or make your mark, make sure that:

(1) You meet your State's requirements, and
(2) You understand **all** of Box 9.

Finally, sign your **full** name or make your mark, and print today's date in this order — Month, Day, Year.
If the applicant is unable to sign, put in **Box D** the name, address, and telephone number (optional) of the person who helped the applicant.

Voter Registration Application

Before completing this form, review the General, Application, and State specific instructions.

Are you a citizen of the United States of America? ☐ Yes ☐ No
Will you be 18 years old on or before election day? ☐ Yes ☐ No
If you checked "No" in response to either of these questions, do not complete form.
(Please see state-specific instructions for rules regarding eligibility to register prior to age 18.)

This space for office use only.

1	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Last Name	First Name	Middle Name(s)	☐ Jr ☐ II ☐ Sr ☐ III ☐ IV
2	Home Address	Apt. or Lot #	City/Town	State	Zip Code
3	Address Where You Get Your Mail If Different From Above		City/Town	State	Zip Code
4	Date of Birth Month Day Year	5	Telephone Number (optional)	6	ID Number - (See item 6 in the instructions for your state)
7	Choice of Party (see item 7 in the instructions for your State)	8	Race or Ethnic Group (see item 8 in the instructions for your State)		

9 I have reviewed my state's instructions and I swear/affirm that:
- I am a United States citizen
- I meet the eligibility requirements of my state and subscribe to any oath required.
- The information I have provided is true to the best of my knowledge under penalty of perjury. If I have provided false information, I may be fined, imprisoned, or (if not a U.S. citizen) deported from or refused entry to the United States.

Please sign full name (or put mark) ▲

Date: ____ / ____ / ____
Month Day Year

If you are registering to vote for the first time: please refer to the application instructions for information on submitting copies of valid identification documents with this form.

Please fill out the sections below if they apply to you.

If this application is for a **change of name**, what was your name before you changed it?

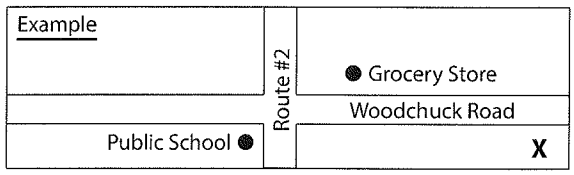
A	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Last Name	First Name	Middle Name(s)	☐ Jr ☐ II ☐ Sr ☐ III ☐ IV

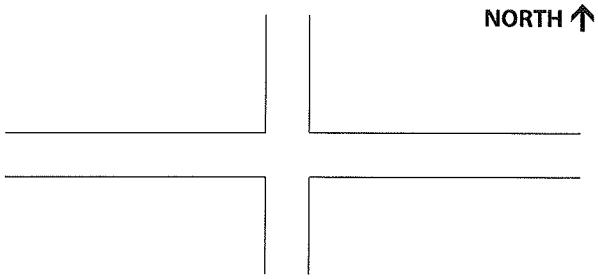
If you were **registered before but this is the first time you are registering from the address in Box 2**, what was your address where you were registered before?

B	Street (or route and box number)	Apt. or Lot #	City/Town/County	State	Zip Code

If you live in a rural area but do not have a street number, or if you have no address, please show on the map where you live.

C
- Write in the names of the crossroads (or streets) nearest to where you live.
- Draw an X to show where you live.
- Use a dot to show any schools, churches, stores, or other landmarks near where you live, and write the name of the landmark.





If the applicant is unable to sign, who helped the applicant fill out this application? Give name, address and phone number (phone number optional).

D

Mail this application to the address provided for your State.

FOR OFFICIAL USE ONLY

FIRST CLASS STAMP NECESSARY FOR MAILING

Print Application

7. Choice of Party. If you are registered in a political party which has qualified for ballot recognition, you will be permitted to vote the primary election ballot for that party. If you are registered as an independent, no party preference or as a member of a party which is not qualified for ballot recognition, you may select and vote one primary election ballot for one of the recognized political parties.
8. Race or Ethnic Group. Leave blank.
9. Signature. To register in Arizona you must:
• be a citizen of the United States
• be a resident of Arizona and your county at least 29 days preceding the next election
• be 18 years old on or before the next general election
• not have been convicted of treason or a felony (or have had your civil rights restored)
• not currently be declared an incapacitated person by a court of law

Mailing address:
Secretary of State/Elections
1700 W. Washington, 7th Floor
Phoenix, AZ 85007-2888

Arkansas

Updated: 03-01-2006

Registration Deadline — 30 days before the election.

6. ID Number. Your completed voter registration form must contain your state issued driver's license number or nonoperating identification number. If you do not have a driver's license or nonoperating identification, you must include the last four digits of your social security number. If you do not have a driver's license or a nonoperating identification or a social security number, please write "NONE" on the form. A unique identifying number will be assigned by the State.
7. Choice of Party. Optional. You do not have to register with a party if you want to take part in that party's primary election, caucus, or convention.
8. Race or Ethnic Group. Leave blank.
9. Signature. To register in Arkansas you must:
• be a citizen of the United States
• live in Arkansas at the address in Box 2 on the application
• be at least 18 years old before the next election
• not be a convicted felon (or have completely discharged your sentence or been pardoned)
• not claim the right to vote in any other jurisdiction
• not previously be adjudged mentally incompetent by a court of competent jurisdiction

Mailing address:
Secretary of State
Voter Services
P.O. Box 8111
Little Rock, AR 72203-8111

California

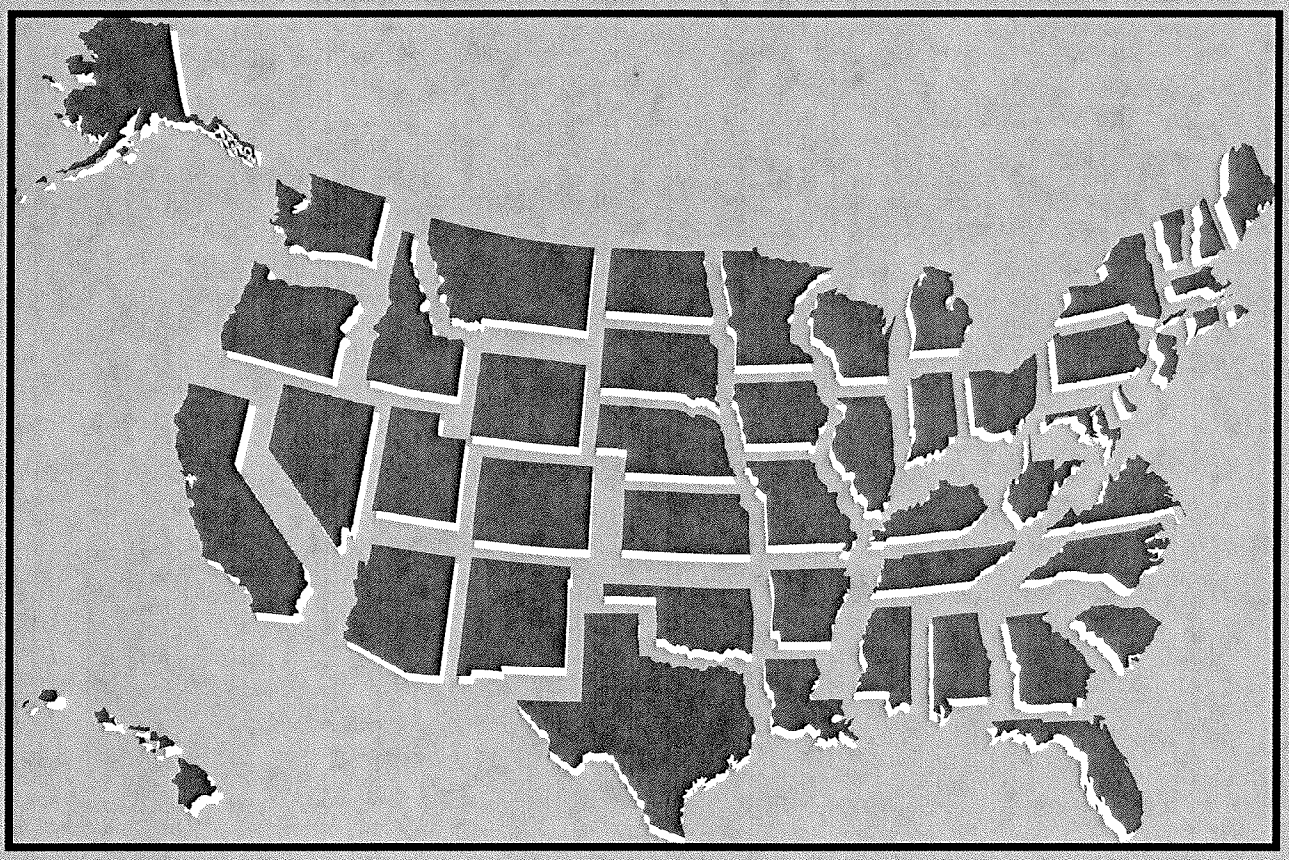
Updated: 03-01-2006

Registration Deadline — 15 days before the election.

6. ID Number. When you register to vote, you must provide your California driver's license or California identification card number, if you have one. If you do not have a driver's license or ID card, you must provide the last four digits of your Social Security Number (SSN). If you do not include this information, you will be required to provide identification when you vote.
7. Choice of Party. Please enter the name of the political party with which you wish to register. If you do not wish to register with any party, enter "Decline to State" in the space provided.
California law allows voters who "decline to state" an affiliation with a qualified political party or who affiliate with a nonqualified political party to vote in the primary election of any qualified political party that files a notice with the Secretary of State allowing them to do so. You can call 1-800-345-VOTE or visit www.sos.ca.gov to learn which political parties are allowing nonaffiliated voters to participate in their primary election.
8. Race or Ethnic Group. Leave blank.
9. Signature. To register in California you must:
• be a citizen of the United States
• be a resident of California
• be at least 18 years of age at the time of the next election
• not be imprisoned or on parole for the conviction of a felony
• not currently be judged mentally incompetent by a court of law
Signature is required. If you meet the requirements listed above, please sign and date the registration card in the space provided.

Mailing address:
Secretary of State
Elections Division
1500 11th Street
Sacramento, CA 95814

Ghi danh Bỏ phiếu tại Tiểu bang của quý vị bằng cách sử dụng Cẩm nang Hướng dẫn và Mẫu đơn dạng Bưu thiệp này



Dành cho các Công dân Hoa Kỳ

Các Hướng dẫn Tổng quát

Ai Có thể Sử dụng Đơn này
Nếu quý vị là công dân Hoa Kỳ đang định cư hoặc có địa chỉ cư ngụ tại Hoa Kỳ, quý vị có thể sử dụng mẫu đơn trong cẩm nang này để:

- Ghi danh bỏ phiếu tại Tiểu bang nơi quý vị đang sống
- Báo cáo thay đổi tên họ với phòng ghi danh bỏ phiếu,
- Báo cáo thay đổi địa chỉ với phòng ghi danh bỏ phiếu, hoặc
- Đăng ký với một đảng chính trị.

Các trường hợp ngoại lệ
Xin đừng sử dụng mẫu đơn này nếu quý vị sống ngoài phạm vi và lãnh thổ Hoa Kỳ hoặc không có địa chỉ thường trú (hợp pháp) tại quốc gia này, hoặc quý vị đang phục vụ nghĩa vụ quân sự xa nhà. Vui lòng sử dụng Đơn xin dạng Bưu thiệp Liên bang (FPCA) có sẵn tại căn cứ quân sự, các Đại sứ quán Mỹ hoặc các tòa lãnh sự.

Các thư ký thành phố và thị trấn của Tiểu bang **New Hampshire** sẽ tiếp nhận đơn này chỉ như là một yêu cầu để xin cấp mẫu đơn ghi danh qua thư dành cho cử tri khiếm diện.
Tiểu bang **North Dakota** không có hệ thống đăng ký cử tri.
Luật pháp Tiểu bang **Wyoming** không cho phép đăng ký qua thư.

Phải Làm Thế Nào Để Biết Quý Vị Có Đủ Điều Kiện Bỏ Phiếu Tại Tiểu Bang Của Mình Hay Không
Mỗi Tiểu bang đều có luật lệ riêng về đăng ký và bỏ phiếu. Xin vui lòng kiểm tra thông tin dành cho Tiểu bang của quý vị trong phần Hướng dẫn của Tiểu bang. Theo quy định của mọi Tiểu bang quý vị phải là một công dân gốc Hoa Kỳ hoặc nhập quốc tịch Hoa Kỳ mới được đăng ký bầu cử tại các cuộc bầu cử tiểu bang hoặc liên bang. Luật Liên bang quy định việc khai gian về quốc tịch công dân Mỹ để đăng ký bỏ phiếu tại bất kỳ một cuộc bầu cử cấp địa phương, tiểu bang hoặc liên bang nào đều là bất hợp pháp. Quý vị không thể đăng ký bỏ phiếu cùng lúc tại hơn một nơi.

Cách Điền Đơn
Để giúp quý vị điền đơn xin vui lòng tham khảo các Hướng dẫn trong Mẫu Đơn và Hướng dẫn của Tiểu bang.

- Trước tiên, hãy đọc kỹ phần Hướng dẫn của Mẫu đơn. Các hướng dẫn này sẽ cung cấp thông tin quan trọng áp dụng cho tất cả những ai sử dụng mẫu đơn này.
- Tiếp đến, xác định Tiểu bang nơi quý vị sinh sống trong phần Hướng dẫn của Tiểu bang. Sử dụng các hướng dẫn này để điền các Ô 6, 7 và 8. Đồng thời, tham khảo các hướng dẫn này để có thông tin về điều kiện cử tri và tuyên thệ để điền Ô 9.
- **XIN VUI LÒNG TRẢ LỜI BẰNG TIẾNG ANH.**

Thời điểm Ghi danh Bỏ phiếu
Mỗi Tiểu bang đều có thời hạn ghi danh bỏ phiếu khác nhau. Xin vui lòng kiểm tra thông tin về thời hạn ghi danh cho Tiểu bang của quý vị ở trang cuối của cẩm nang này.

Cách Nộp Đơn Bỏ Phiếu
Gửi mẫu đơn của quý vị tới địa chỉ được ấn định trong phần Hướng dẫn của Tiểu bang. Hoặc trực tiếp nộp đơn tại phòng ghi danh cử tri địa phương. Theo quy định các Tiểu bang nào bắt buộc phải tiếp nhận mẫu đơn quốc gia sẽ phải tiếp nhận các bản sao của mẫu đơn được in trên cỡ giấy bình thường từ máy vi tính, có chữ ký của người đứng đơn, và được gửi qua đường bưu điện trong phong bì có đủ bưu phí.

Ghi Danh Bỏ Phiếu Qua Thư Đối Với Các Cử Tri Tham Gia Bỏ Phiếu Lần Đầu
Nếu quý vị ghi danh bỏ phiếu lần đầu tiên trong khu vực có thẩm quyền pháp lý của mình và nộp đơn ghi danh cử tri này bằng thư, luật Liên Bang, đòi hỏi quý vị phải trình giấy tờ chứng minh danh tính khi bỏ phiếu lần đầu tiên. Giấy tờ chứng minh danh tính bao gồm:

- Một căn cước hiện hành có hình ảnh và có hiệu lực; HOẶC
- Một hóa đơn hiện hành thuộc các công ty tiện ích (điện, ga, nước) , bảng kết toán của ngân hàng, chi phiếu chính phủ, chi phiếu lương, hay các văn kiện của chính phủ có ghi tên và địa chỉ của quý vị.

Các cử tri có thể được miễn quy định này nếu họ nộp **BẢN SAO** của các giấy tờ chứng minh danh tính kèm theo mẫu đơn ghi danh cử tri qua thư. Nếu quý vị muốn nộp **BẢN SAO**, xin lưu ý các điều sau đây:

- Tiểu bang nơi quý vị sinh sống có thể có các yêu cầu bổ túc thêm về giấy tờ xác minh danh tính, và yêu cầu quý vị phải trình căn cước tại địa điểm bỏ phiếu cho dù quý vị đã đáp ứng các yêu cầu xác minh danh tính của Liên bang.
- Đừng nộp các giấy tờ gốc kèm theo đơn này, chỉ nộp **BẢN SAO** mà thôi.

Nếu Quý Vị Nhận Mẫu Đơn Này Tại Một Cơ Quan Của Tiểu Bang Hoặc Văn Phòng Chính phủ
Nếu Quý vị nhận mẫu đơn này tại một Cơ quan Chính quyền Tiểu bang hoặc Văn phòng Chính phủ, quý vị được tùy ý sử dụng đơn này. Nếu quý vị muốn sử dụng đơn để ghi danh bỏ phiếu, quý vị có thể hoàn tất đơn và để lại với Cơ quan Chính quyền Tiểu bang hoặc Văn phòng Chính phủ đó. Họ sẽ nộp đơn cho quý vị. Hoặc quý vị có thể gửi trực tiếp tới địa chỉ được ấn định theo Tiểu bang nơi quý vị sinh sống trong phần Hướng dẫn của Tiểu bang. Ngoài ra, quý vị cũng có thể trực tiếp mang đến phòng ghi danh cử tri địa phương.
Lưu ý: Tên và địa điểm của Cơ quan Chính quyền Tiểu bang hoặc văn phòng chính phủ nơi quý vị nhận được đơn xin đăng ký sẽ được giữ kín đáo. Thông tin này sẽ không hiện trên đơn xin đăng ký của quý vị. Ngoài ra, nếu quý vị không sử dụng đơn xin đăng ký này để ghi danh cử tri, thì việc đó cũng sẽ được giữ kín đáo. Quyết định này sẽ không ảnh hưởng tới dịch vụ mà quý vị nhận được từ cơ quan hoặc văn phòng nói trên.

Hướng dẫn Điền Đơn

Trước khi điền mẫu đơn, xin trả lời các câu hỏi ở phần trên của mẫu đơn để xác nhận quý vị có phải là công dân Hoa Kỳ hay không và quý vị đã đủ 18 tuổi trước Ngày Bầu cử hay chưa. Nếu quý vị trả lời không đối với bất kỳ câu hỏi nào trong hai câu hỏi đó, quý vị sẽ không được phép sử dụng mẫu đơn này để ghi danh bỏ phiếu. Tuy nhiên, các hướng dẫn riêng của tiểu bang có thể cung cấp các thông tin thêm về điều kiện ghi danh bỏ phiếu trước 18 tuổi.

Ô 01 — Tên
Trong ô này hãy điền trọn tên họ của quý vị theo thứ tự như sau - tên Họ, tên Gọi, tên Đệm. Đừng dùng các tên bí danh hoặc tên viết tắt.
Lưu ý: Nếu dùng đơn này để thay đổi tên, vui lòng ghi rõ trong **Ô A** *(ở phần dưới của mẫu đơn)* trọn tên họ của quý vị trước khi quý vị thay đổi tên mới.

Ô 02 — Địa chỉ Cư ngụ
Trong ô này hãy điền địa chỉ cư ngụ của quý vị (địa chỉ hợp pháp). Đừng ghi địa chỉ nhận thư ở đây nếu khác với địa chỉ cư ngụ của quý vị. Đừng sử dụng địa chỉ hộp thư của bưu điện hoặc tuyến đường giao thư tại khu vực nông thôn mà không có số hiệu hộp thư. Tham khảo các hướng dẫn riêng của tiểu bang về nguyên tắc sử dụng số hiệu hộp thư cho các tuyến đường giao thư.

Lưu ý: Lưu ý: Nếu trước đây quý vị đã từng đăng ký bỏ phiếu nhưng đây là lần đầu tiên quý vị đăng ký từ địa chỉ ghi trong Ô 2, vui lòng ghi vào **Ô B** (*ở phần dưới của mẫu đơn*) địa chỉ nơi quý vị đã đăng ký trước đó. Xin cung cấp tất cả các chi tiết thuộc địa chỉ trước mà quý vị có thể nhớ được.

Lưu ý: Nếu quý vị sống ở khu vực nông thôn nhưng lại không có địa chỉ tên đường, hoặc nếu quý vị không có địa chỉ, xin cho biết nơi cư ngụ của quý vị bằng cách mô tả trên bản đồ ở trong **Ô C** *(phần cuối của mẫu đơn).*

Ô 03 — Địa chỉ Nhận thư
Nếu quý vị nhận thư tại một địa chỉ khác với địa chỉ trong Ô 2, xin ghi rõ địa chỉ nhận thư vào trong Ô này. Nếu trong Ô 2 quý vị không ghi địa chỉ thì, trong Ô 3 quý vị phải ghi một địa chỉ để liên lạc bằng thư.

Ô 04 — Ngày sinh
Điền vào ô này ngày tháng năm sinh của quý vị theo thứ tự như sau- Tháng, Ngày, Năm. *Lưu ý đừng sử dụng ngày tháng hôm nay!*

Ô 05 — Số Điện thoại
Đa số các tiểu bang đều yêu cầu quý vị cung cấp số điện thoại để phòng trường hợp có thắc mắc nào liên quan đến đơn xin của quý vị. Tuy nhiên, quý vị không cần phải điền vào ô này.

Ô 06 — Số Căn cước
Luật Liên bang yêu cầu các tiểu bang phải lấy số căn cước của mỗi người đăng ký bỏ phiếu. Quý vị phải tham khảo các hướng dẫn riêng thể của từng tiểu bang, đối với Ô 06, để biết xem loại căn cước nào là hợp lệ đối với tiểu bang của quý vị. Nếu quý vị không có bằng lái xe hay số an sinh xã hội, vui lòng ghi rõ điều này trong đơn và Chính quyền Tiểu bang sẽ cấp một mã số nhận diện riêng cho quý vị.

Ô 07 — Chọn Chính Đảng
Ở một số Tiểu bang, quý vị phải đăng ký với một chính đảng nếu quý vị muốn tham gia cuộc bầu cử sơ bộ, họp kín hoặc hội nghị của đảng đó. Để xác định xem Tiểu bang của quý vị có quy định này hay không, xin tham khảo mục 07 trong phần hướng dẫn của Tiểu bang nơi quý vị sinh sống.

Nếu quý vị muốn đăng ký theo một chính đảng, hãy điền vào ô trống trọn tên của chính đảng mà quý vị đã chọn.

Nếu quý vị không muốn đăng ký theo một chính đảng, hãy viết "không chọn đảng" hoặc để ô trống. Đừng viết "độc lập" nếu quý vị có ý "không chọn đảng" vì từ này sẽ gây nhầm lẫn với tên của một đảng chính trị tại tiểu bang của quý vị .
Lưu ý: Nếu không đăng ký theo một chính đảng, quý vị vẫn có thể bầu cử trong các cuộc tổng tuyển cử và bầu cử sơ bộ không theo chính đảng.

Ô 08 — Chủng tộc hoặc Sắc tộc
Một số Tiểu bang sẽ yêu cầu thông tin về chủng tộc hoặc sắc tộc của quý vị để thực thi Đạo Luật về Quyền Bỏ phiếu Liên bang. Để xác định xem Tiểu bang của quý vị có yêu cầu thông tin này không, xin tham khảo mục 08 trong phần hướng dẫn của Tiểu Bang nơi quý vị sinh sống. Nếu có, xin ghi thông tin nào hợp nhất để mô tả chủng tộc của quý vị vào Ô 08:

- Thổ dân Châu Mỹ hoặc Gốc Alaska
- Gốc Châu Á hoặc Gốc Đảo Thái Bình Dương
- Người da đen không thuộc gốc Nam Mỹ
- Người Nam Mỹ
- Người đa chủng tộc
- Người da trắng không thuộc gốc Nam Mỹ
- Khác

Ô 09 — Chữ ký
Vui lòng xem phần thông tin trong mục 09 ở phần hướng dẫn của Tiểu bang nơi quý vị sinh sống. Trước khi ký tên hoặc đánh dấu, hãy chắc chắn rằng:

(1) Quý vị đã đáp ứng mọi yêu cầu của Tiểu bang, và
(2) Quý vị hiểu rõ tất cả nội dung trong Ô 09.

Cuối cùng, hãy ký rõ trọn tên hoặc đánh dấu xác nhận, và ghi rõ ngày tháng hiện tại theo thứ tự như sau- Tháng, Ngày, Năm. Nếu người đứng đơn không thể ký tên, hãy ghi vào **Ô D** tên họ, địa chỉ và số điện thoại (tùy ý) của người đã trợ giúp điền đơn.

Voter Registration Application/Đơn Xin Ghi Danh Bỏ Phiếu

Before completing this form, review the General, Application, and State specific instructions.
Trước khi hoàn tất mẫu đơn này, xin xem lại các Hướng dẫn Tổng Quát, Hướng dẫn Điền đơn và Hướng dẫn riêng của Tiểu bang.
PLEASE PROVIDE YOUR RESPONSES IN ENGLISH. / XIN VUI LÒNG TRẢ LỜI BẰNG TIẾNG ANH.

Are you a citizen of the United States of America? / Quý vị có phải là công dân Hoa Kỳ hay không? [ ]

Will you be 18 years old on or before election day? / Quý vị có đủ 18 tuổi trước hoặc vào ngày bầu cử hay không? [ ]

If you check "No" in response to either of these questions, do not complete form.
Nếu quý vị trả lời "Không" đối với một trong hai câu hỏi này, xin đừng tiếp tục điền mẫu đơn nữa.
(Please see state-specific instructions for rules regarding eligibility to register prior to age 18.)
(Vui lòng xem các hướng dẫn riêng của tiểu bang về quy định hội điều kiện ghi danh trước 18 tuổi).

This space for office use only. / Phần này chỉ dành cho văn phòng bầu cử.

1		Last Name / Tên họ	First Name / Tên gọi	Middle Name(s) / Tên đệm	
2	Home Address / Địa chỉ cư ngụ		Apt. or Lot # / Apt. hoặc Lot #	City/Town / Thành phố/Thị trấn	State / Tiểu bang	Zip Code / Số Zip Code
3	Address Where You Get Your Mail If Different From Above / Địa chỉ Nhận Thư nếu khác với Địa chỉ ở Trên			City/Town / Thành phố/Thị trấn	State / Tiểu bang	Zip Code / Số Zip Code

4	Date of Birth/ Ngày sinh / / Month / Tháng Day / Ngày Year / Năm	5	Telephone Number (optional) / Số Điện thoại (tùy ý)	6	ID Number (See Item 6 in the instructions for your state) / Số Căn cước (Xem mục 06 trong phần hướng dẫn dành cho tiểu bang nơi quý vị sinh sống)
7	Choice of Party (see item 7 in the instructions for your State) / Chọn Chính Đảng (Xem mục 07 trong phần hướng dẫn dành cho tiểu bang nơi quý vị sinh sống)	8	Race or Ethnic Group (see item 8 in the instructions for your State) / Chủng tộc hoặc Sắc tộc (Xem mục 08 trong phần hướng dẫn dành cho tiểu bang nơi quý vị sinh sống)		

9 I have reviewed my state's instructions and I swear/affirm that: /
Tôi đã đọc kỹ các hướng dẫn liên quan đến tiểu bang nơi tôi sinh sống và tôi xin thề/xác nhận rằng:

- I am a United States citizen / Tôi là công dân Hoa Kỳ
- I meet the eligibility requirements of my state and subscribe to any oath required. / Tôi đáp ứng đầy đủ các yêu cầu của tiểu bang và đồng ý với bất kỳ quy định tuyên thệ nào cần thiết.
- The information I have provided is true to the best of my knowledge under penalty of perjury. If I have provided false information, I may be fined, imprisoned, or (if not a U.S. citizen) deported from or refused entry to the United States. / Các thông tin mà tôi đã cung cấp là đúng với sự thật dựa trên sự hiểu biết tốt nhất của tôi chiếu theo luật và hình phạt khai gian. Nếu tôi cung cấp sai thông tin, tôi sẽ bị phạt tiền, bị tù giam, hoặc (nếu không phải là công dân Hoa Kỳ) sẽ bị trục xuất hoặc không cho phép nhập cảnh vào nước Mỹ.

Please sign full name (or put mark) / Xin ký trọn tên họ (hoặc làm dấu xác nhận) ▲

Date / Ngày: / / Month /Tháng Day / Ngày Year / Năm

If you are registering to vote for the first time: please refer to the application instructions for information on submitting copies of valid identification documents with this form.
Nếu quý vị ghi danh bỏ phiếu lần đầu tiên: xin vui lòng tham khảo các hướng dẫn điền đơn để biết về cách thức nộp bản sao đối với các giấy tờ chứng minh danh tính để gởi kèm theo mẫu đơn này cho hợp lệ.

Please fill out the sections below if they apply to you.
Xin điền các mục sau đây nếu phù hợp với quý vị.

If this application is for a **change of name**, what was your name before you changed it? /Nếu đơn này dùng để thay đổi tên họ, xin cho biết tên của quý vị là gì trước khi đổi tên?

A		Last Name / Tên ho	First Name / Tên gọi	Middle Name(s) / Tên đệm	

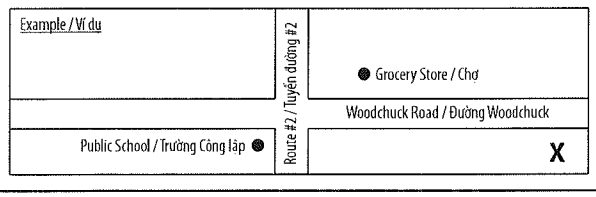
If you were **registered before but this is the first time you are registering from the address in Box 2**, what was your address where you were registered before?
Nếu quý **vị đã đăng ký từ trước nhưng đây là lần đầu tiên quý vị đăng ký từ địa chỉ ghi trong Ô 2**, thì xin cho biết địa chỉ mà quý vị đã đăng ký trước đó là gì?

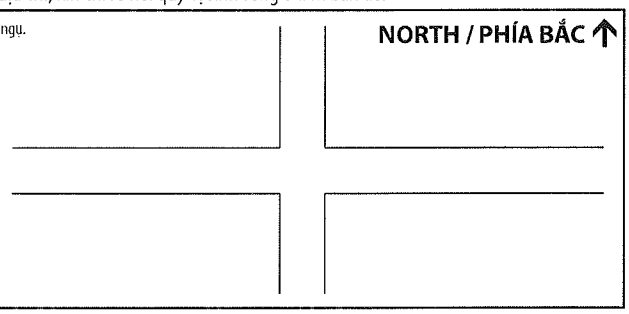
B	Street (or route and box number) / Tên Đường (hoặc số hiệu hộp thư hoặc số tuyến đường giao thư)	Apt. or Lot # / Apt. hoặc Lot #	City/Town/County / Thành phố/Thị trấn/Quận	State / Tiểu bang	Zip Code / Số Zip Code

If you live in a rural area but do not have a street number, or if you have no address, please show on the map where you live.
Nếu quý vị sống ở khu vực nông thôn nhưng lại không có địa chỉ tên đường, hoặc nếu quý vị không có địa chỉ, xin chỉ rõ nơi quý vị sinh sống ở trên bản đồ.

C

- Write in the names of the crossroads (or streets) nearest to where you live. / Ghi rõ tên các giao lộ (hoặc đường gần nhất nơi quý vị cư ngụ.
- Draw an X to show where you live. / Đánh dấu X để chỉ rõ nơi quý vị cư ngụ.
- Use a dot to show any schools, churches, stores, or other landmarks near where you live, and write the name of the landmark. / Sử dụng chấm nhỏ để biểu thị trường học, nhà thờ, cửa hàng hoặc các điểm mốc định hướng khác gần nơi quý vị cư ngụ và ghi rõ tên của điểm mốc định hướng đó.





If the applicant is unable to sign, who helped the applicant fill out this application? Give name, address and phone number (phone number optional).
Trong trường hợp người đứng đơn không thể ký tên, xin cho biết ai là người đã giúp điền đơn này? Ghi rõ tên, địa chỉ và số điện thoại (số điện thoại không bắt buộc).

D

Mail this application to the address provided for your State.
Gửi đơn đăng ký này tới địa chỉ được ấn định ở Tiểu bang nơi quý vị đang sinh sống.

Sửa đổi ngày 10/29/2003

FOR OFFICIAL USE ONLY CHỈ DÀNH CHO VIÊN CHỨC PHỤ TRÁCH BỎ PHIẾU

FIRST CLASS STAMP NECESSARY FOR MAILING

Print Application

cấp cho quý vị một mã số nhận diện riêng để ghi danh bầu cử.

7. Chọn Chính Đảng. Nếu quý vị đã đăng ký theo một chính đảng được công nhận hội đủ điều kiện bỏ phiếu, quý vị sẽ được phép bỏ phiếu trong cuộc bầu cử sơ bộ của chính đảng đó. Nếu quý vị đăng ký dưới dạng độc lập, hoặc không thiên về đảng nào hoặc đăng ký là thành viên của đảng không đủ tiêu chuẩn được công nhận bỏ phiếu, quý vị có thể lựa chọn và bỏ phiếu cho một lá phiếu bầu cử sơ bộ của một trong các chính đảng khác đã được công nhận.

8. Chủng tộc hoặc Sắc tộc. Bỏ trống

9. Chữ ký. Để ghi danh tại Arizona, quý vị phải:

- là công dân Hoa Kỳ
- là cư trú nhân ở Arizona và cư ngụ tại quận hạt của mình ít nhất là 29 ngày trước cuộc bầu cử kế tiếp
- đủ 18 tuổi trước hoặc vào ngày diễn ra cuộc tổng tuyển cử kế tiếp
- chưa từng bị kết án về tội phản quốc hoặc trọng tội (hoặc đã được phục hồi các dân quyền và chính trị)
- hiện không bị tòa tuyên là người mất khả năng

Địa chỉ gửi thư:

Secretary of State/Elections
1700 W. Washington, 7th Floor
Phoenix, AZ 85007-2888

Arkansas

Cập nhật ngày: 03-01-2006

Thời hạn Chót để Đăng ký — 30 ngày trước ngày bầu cử.

6. Số Căn cước. Khi hoàn tất mẫu đơn ghi danh cử tri quý vị phải kèm theo số bằng lái xe hoặc số thẻ căn cước khác được cấp tại tiểu bang nơi quý vị sinh sống . Nếu không có Bằng Lái xe hoặc Số Thẻ Căn cước khác, quý vị phải cung cấp bốn số cuối trong số An sinh Xã hội của quý vị. Nếu quý vị không có bằng lái xe hoặc thẻ căn cước khác hoặc số an sinh xã hội, xin viết "KHÔNG" vào mẫu đơn. Chính quyền Tiểu bang sẽ cấp cho quý vị một mã số nhận diện riêng để ghi danh bầu cử.

7. Lựa chọn Chính Đảng. Tùy ý. Quý vị không cần phải đăng ký theo một chính đảng nếu muốn tham gia cuộc bầu cử sơ bộ, họp kín hoặc hội nghị của đảng đó.

8. Chủng tộc hoặc Sắc tộc. Bỏ trống

9. Chữ ký. Để ghi danh tại Arkansas, quý vị phải:

- là công dân Hoa Kỳ
- cư ngụ tại Arkansas theo đúng địa chỉ ghi trong Ô 02 của đơn xin đăng ký
- đủ 18 tuổi trước cuộc bầu cử kế tiếp
- không phải là phạm nhân trọng tội (hoặc đã hoàn tất bản án hoặc đã được xóa tội)
- không đòi quyền bỏ phiếu tại khu vực thẩm quyền pháp lý nào khác
- chưa từng bị một tòa án có thẩm quyền tuyên là người kém khả năng trí tuệ

Địa chỉ gửi thư:

Secretary of State
Voter Services
P.O. Box 8111
Little Rock, AR 72203-8111

California

Cập nhật ngày: 03-01-2006

Thời hạn Chót để Đăng ký — 15 ngày trước ngày bầu cử.

6. Số Căn cước. Khi ghi danh bầu cử, quý vị phải cung cấp số bằng lái xe California hoặc số thẻ căn cước California, nếu có. Nếu không có Bằng Lái xe hoặc Số Thẻ Căn cước, quý vị phải cung cấp bốn số cuối trong số An sinh Xã hội của quý vị (SSN). Nếu không cung cấp thông tin này trước, vào lúc ghi danh, thì quý vị phải trình căn cước khi đi bỏ phiếu.

7. Chọn Chính Đảng. Xin vui lòng ghi tên chính đảng mà quý vị muốn đăng ký theo. Nếu không muốn đăng ký theo bất cứ đảng nào, vui lòng ghi "Từ chối Tuyên bố" vào ô sẵn có. Luật Tiểu bang California cho phép các cử tri nào "từ chối tuyên bố" sự liên kết với một chính đảng đã đủ điều kiện hoặc liên kết với một chính đảng chưa đủ điều kiện được phép bầu cử trong phiên bầu cử sơ bộ của bất cứ chính đảng nào đã đủ điều kiện nếu đảng đó đã trình thông báo và có sự đồng ý của Tổng trưởng Bang cho phép đảng đó được tham gia bầu cử. Quý vị có thể gọi số 1-800-345-VOTE hoặc vào trang web www.ss.ca.gov để biết các chính đảng nào cho phép cử tri không liên kết được phép tham gia bầu cử sơ bộ.

8. Chủng tộc hoặc Sắc tộc. Bỏ trống

9. Chữ ký. Để ghi danh tại California, quý vị phải:

- là công dân Hoa Kỳ
- là cư trú nhân của Tiểu bang California
- đủ 18 tuổi vào thời điểm diễn ra cuộc bầu cử kế tiếp
- không bị tù giam hoặc đã được tạm phóng thích sau khi phạm trọng tội
- hiện không bị tòa án có thẩm quyền tuyên là người kém khả năng trí tuệ

Bắt buộc phải có chữ ký xác nhận. Nếu quý vị đáp ứng các yêu cầu trên đây, vui lòng ký tên và đề ngày trên thẻ đăng ký trong phần ô trống sẵn có.

Các Hướng dẫn Riêng của Tiểu bang

Địa chỉ gửi thư:
Secretary of State
Elections Division
1500 11th Street
Sacramento, CA 95814

Colorado

Cập nhật ngày: 03-28-2008

Thời hạn Chót để Đăng ký — 29 ngày trước ngày bầu cử. Nếu văn phòng ghi danh cử tri nhận đơn đăng ký qua thư nhưng không có dấu đóng của bưu điện, thì đơn đăng ký đó phải được nhận trong vòng 05 ngày kể từ ngày kết thúc thời hạn đăng ký.

6. Số Căn cước. Khi hoàn tất mẫu đơn ghi danh cử tri quý vị phải kèm theo số bằng lái xe được cấp tại Tiểu bang nơi quý vị sinh sống hoặc số thẻ căn cước. Nếu không có Bằng Lái xe hoặc Số Thẻ Căn cước của Tiểu bang, quý vị phải cung cấp bốn số cuối trong số An sinh Xã hội của quý vị. Nếu quý vị không có bằng lái xe hoặc thẻ căn cước do Tiểu bang cấp hoặc số an sinh xã hội, xin viết "KHÔNG" vào mẫu đơn. Chính quyền Tiểu bang sẽ cấp cho quý vị một mã số nhận diện riêng để ghi danh bầu cử.

7. Chọn Chính Đảng. Quý vị phải đăng ký theo một chính đảng nếu muốn tham gia cuộc bầu cử sơ bộ, họp kín hoặc hội nghị của đảng đó.

8. Chủng tộc hoặc Sắc tộc. Bỏ trống

9. Chữ ký. Để ghi danh tại Colorado, quý vị phải:

- là công dân Hoa Kỳ
- là cư trú nhân của Tiểu bang Colorado trong 30 ngày trước ngày bầu cử
- đủ 18 tuổi trước hoặc trong ngày bầu cử
- không bị tù giam hoặc không thụ bất kỳ một phần của bản án nào theo lệnh tòa

Địa chỉ gửi thư:
Colorado Secretary of State
1700 Broadway, Suite 270
Denver, Colorado 80290

Connecticut

Cập nhật ngày: 03-01-2006

Thời hạn Chót để Đăng ký — 14 ngày trước ngày bầu cử.

6. Số Căn cước. Bằng Lái xe do Tiểu bang Connecticut cấp hoặc nếu không có, thì bốn số cuối trong số An sinh Xã hội.

7. Chọn Chính Đảng. Phần này là tùy ý, nhưng quý vị phải đăng ký theo một chính đảng nếu quý vị muốn tham gia cuộc bầu cử sơ bộ, họp kín hoặc hội nghị của đảng đó.

8. Chủng tộc hoặc Sắc tộc. Bỏ trống

9. Chữ ký. Để ghi danh tại Connecticut, quý vị phải:

- là công dân Hoa Kỳ
- là cư trú nhân ở Connecticut và của thị trấn nơi quý vị muốn bỏ phiếu
- đủ 17 tuổi. Quý vị có thể bỏ phiếu khi đủ tuổi 18.
- đã mãn hạn tù và mãn lệnh tạm phóng thích nếu từng phạm trọng tội và được Nhân viên Ghi danh Cử tri phục hồi quyền bầu cử.
- hiện không bị tòa có thẩm quyền tuyên là người kém khả năng trí tuệ

Địa chỉ gửi thư:
Secretary of State
Elections Division
30 Trinity Street
Hartford, CT 06106

Delaware

Cập nhật ngày: 02-07-2012

Thời hạn Chót để Đăng ký — Ngày Thứ Bảy của Tuần thứ tư trước cuộc tổng tuyển cử hoặc bầu cử sơ bộ, và 10 ngày trước cuộc bầu cử đặc biệt.

6. Số Căn cước. Khi hoàn tất mẫu ghi danh cử tri quý vị phải kèm theo số bằng lái xe hoặc số thẻ căn cước khác cấp tại tiểu bang nơi quý vị sinh sống. Nếu không có Bằng Lái xe hoặc Số Thẻ Căn cước khác, quý vị phải cung cấp bốn số cuối trong số An sinh Xã hội của quý vị. Nếu quý vị không có bằng lái xe hoặc thẻ căn cước khác hoặc số an sinh xã hội, xin viết "KHÔNG" vào mẫu đơn. Chính quyền Tiểu bang sẽ cấp cho quý vị một mã số nhận diện riêng để ghi danh bầu cử.

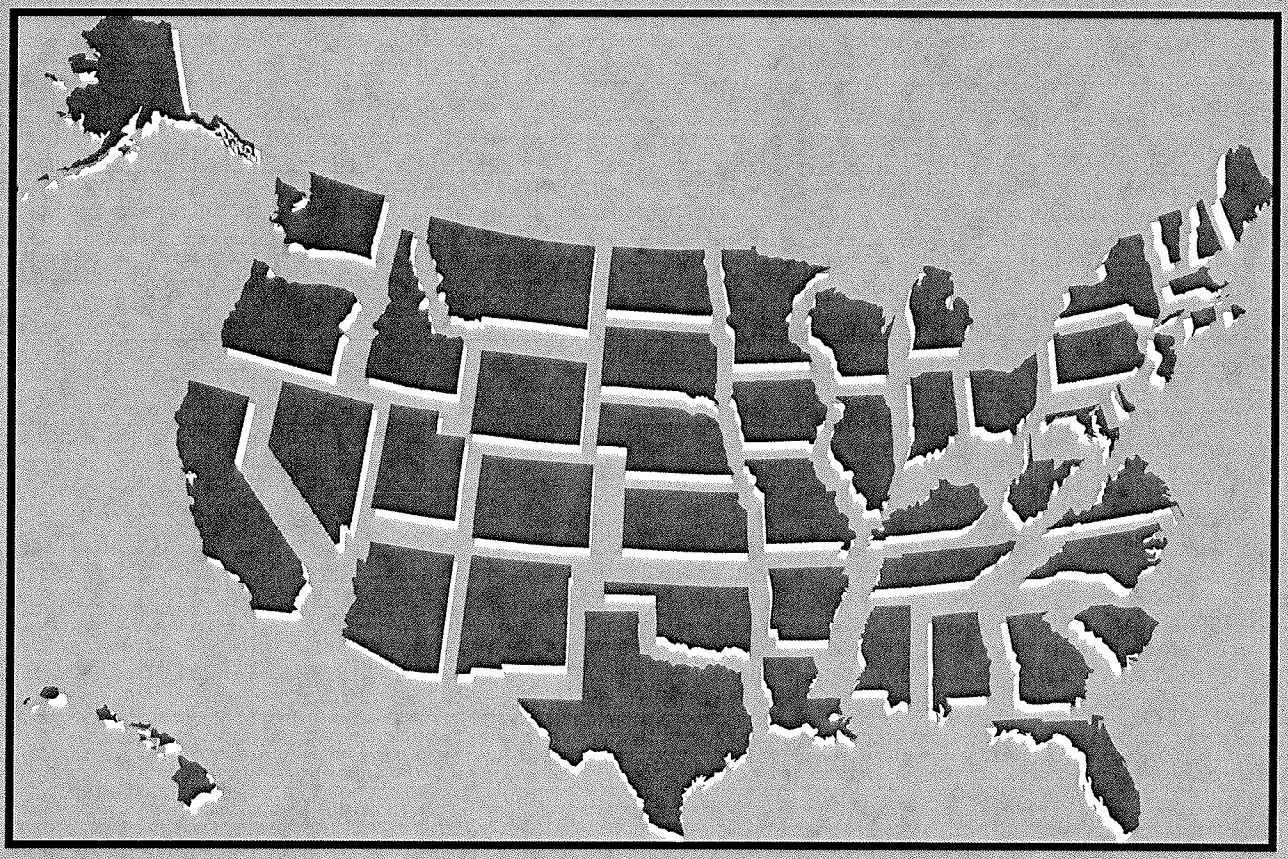
7. Chọn Chính Đảng. Quý vị phải đăng ký theo một chính đảng nếu quý vị muốn tham gia cuộc bầu cử sơ bộ, họp kín hoặc hội nghị của đảng đó.

8. Chủng tộc hoặc Sắc tộc. Bỏ trống

9. Chữ ký. Để ghi danh tại Delaware, quý vị phải:

- là công dân Hoa Kỳ
- là thường trú nhân của Delaware
- đủ tuổi 18 vào ngày diễn ra cuộc tổng tuyển cử kế tiếp
- các phạm nhân trọng tội vẫn có thể bỏ phiếu nếu đáp ứng các yêu cầu sau: đã hoàn tất các bản án và án phạt tiền ít nhất 5 năm trước ngày ghi danh bỏ phiếu; các bản án không thuộc các trọng tội như giết người, xâm hại tình dục, các tội danh thuộc ngành công chính như hối lộ, lạm dụng quyền lực hoặc chức vụ.
- không bị kém khả năng trí tuệ

Inscríbase para votar en su estado empleando esta guía y solicitud de inscripción



Para ciudadanos de Estados Unidos

Instrucciones Generales

Quienes pueden usar esta solicitud
Si usted es ciudadano de Estados Unidos que vive o tiene una dirección en Estados Unidos, puede usar la solicitud en este folleto para:

- inscribirse para votar en su estado,
- informar un cambio de nombre a la oficina de inscripción de votantes,
- informar un cambio de dirección a la oficina de inscripción de votantes, o
- inscribirse en un partido político.

Excepciones
No use esta solicitud si vive fuera de Estados Unidos y sus territorios y no tiene un domicilio (legal) en este país o si está en servicio militar estacionado fuera de su hogar. Use la solicitud federal de tarjeta postal disponible en las bases militares, las embajadas y los consulados de Estados Unidos.

Los secretarios municipales de **New Hampshire** aceptan esta solicitud sólo como pedido de su propio formulario de inscripción de votante ausente por correo.
Dakota del Norte no tiene inscripción de votantes.
En **Wyoming** la ley no permite la inscripción de votantes por correo.

Como averiguar si cumple con los requisitos para inscribirse como votante en su estado
Cada estado tiene sus propias leyes sobre quienes pueden inscribirse y votar. Consulte la información correspondiente a su estado en la sección de Instrucciones de los Estados. Todos los estados requieren que usted sea ciudadano de Estados Unidos de nacimiento o naturalizado para inscribirse para votar en las elecciones federales y estatales. La ley federal hace que sea ilegal que una persona indique falsamente que es ciudadana de Estados Unidos para inscribirse para votar en cualquier elección federal, estatal o local. **No puede** estar inscrito para votar en más de un lugar a la vez.

Como llenar esta solicitud
Use las Instrucciones de la Solicitud y las Instrucciones de su Estado como guía para llenar la solicitud.

- Primero lea las Instrucciones de la Solicitud. Esas instrucciones le proporcionan información importante correspondiente a todos los que usan esta solicitud.
- Después encuentre su estado en las Instrucciones de los Estados. Use esas instrucciones para llenar las Casillas 6, 7 y 8. También consulte esas instrucciones para información sobre los requisitos para votar y el juramento requerido en la Casilla 9.
- **PROPORCIONE SUS RESPUESTAS EN INGLÉS.**

Cuando tiene que inscribirse para votar
Cada estado tiene su propia fecha límite para inscribirse para votar. Consulte la fecha límite de su estado en la última página de este folleto.

Como presentar su solicitud
Envíe su solicitud por correo a la dirección indicada para su estado en las Instrucciones de los Estados o entregue la solicitud en persona en la oficina local de inscripción de votantes. Los estados que aceptan el formulario nacional aceptarán una copia de la solicitud impresa de la imagen de la computadora en papel normal, firmada por el solicitante y enviada en un sobre con el franqueo correcto.

Votantes por primera vez que se inscriben por correo
Si se está inscribiendo para votar por primera vez en su jurisdicción y está enviando esta solicitud de inscripción por correo, usted tendrá por ley federal que presentar prueba de identificación la primera vez que vote. Modos de identificación aprobados incluyen:

- Una identificación con foto válida y vigente, o
- Una factura actual de suministro de energía, estado de cuenta bancario, cheque del gobierno, cheque de sueldo o documento que muestre su nombre y dirección.

Los votantes pueden ser exentos de este requisito si envían una **COPIA** de uno de los modos aprobados de identificación junto con su solicitud de inscripción por correo. Si desea enviar una **COPIA** mantenga en mente lo siguiente:

- Su estado puede tener requisitos adicionales de identificación que pueden poner bajo mandato que usted muestre identificación en las mesas electorales incluso si usted cumple con la prueba federal de identificación.
- No envíe el documento original de identificación con esta solicitud, solo envíe **COPIAS**.

Si le entregaron esta solicitud en una entidad de su estado o en una oficina pública
Si le entregaron esta solicitud en una entidad de su estado o en una oficina pública, es su opción usarla o no. Si decide usar esta solicitud para inscribirse para votar, puede llenarla y dejarla en la entidad u oficina pública estatal. El personal de la misma se encargará de tramitarla.
O, si lo desea, la puede enviar a la dirección postal que figura bajo su estado en las Instrucciones de los Estados. También, la puede entregar en persona a la oficina local de inscripción de votantes.
Nota: El nombre y la ubicación de la entidad local o de la oficina pública en que le entregaron la solicitud permanecerá confidencial. No aparecerá en su solicitud. Además, si decide no usar esta solicitud para inscribirse para votar, esa decisión permanecerá confidencial. No afectará el servicio que recibe de la entidad u oficina.

Instrucciones para llenar la solicitud

Antes de llenar la parte principal del formulario, conteste las preguntas en la parte de arriba del formulario para indicar si es ciudadano de Estados Unidos y si habrá cumplido los 18 años de edad para el día de las elecciones. Si contesta "no" a alguna de estas preguntas, no puede usar el formulario para inscribirse para votar. Sin embargo, las instrucciones específicas del estado le pueden proporcionar más información sobre el cumplimiento de los requisitos para votar antes de cumplir 18 años de edad.

Casilla 1 – Nombre
Escriba su nombre en esta casilla en el siguiente orden: apellido, primer nombre, segundo nombre. No use apodos ni iniciales.
Nota: Si esta solicitud es para un cambio de nombre, escriba lo que fue su nombre completo antes de cambiarlo en la **Casilla A** (*en la mitad inferior del formulario*).

Casilla 2 – Domicilio particular
Escriba la dirección donde vive (su dirección legal) en esta casilla. **No** ponga aquí su dirección postal si no es la misma que su dirección particular. **No** use una casilla de correo o una ruta rural sin un número de casilla. Consulte las instrucciones específicas de su estado para las reglas correspondientes a los números de rutas.

Nota: Si estuvo inscrito para votar anteriormente pero esta es la primera vez que se inscribe para la dirección en la Casilla 2, indique la dirección en que estaba inscrito anteriormente en la **Casilla B** (*en la mitad inferior del formulario*). Dénos todo lo que pueda recordar de la dirección anterior.

Nota adicional: Si vive en una zona rural y no tiene una dirección con calle y número o si no tiene dirección, muestre donde vive usando el mapa en la **Casilla C** (*en la parte inferior del formulario*).

Casilla 3 – Dirección postal
Si recibe su correo en un lugar que no es el mismo de la Casilla 2, ponga su dirección postal en esta casilla. Si no tiene dirección en la Casilla 2, **tiene** que escribir en la Casilla 3 una dirección en la que se lo pueda contactar por correo.

Casilla 4 – Fecha de nacimiento
Ponga en esta casilla su fecha de nacimiento en este orden: mes, día año. *¡Tenga cuidado de no usar la fecha de hoy!*

Casilla 5 – Número de teléfono
La mayoría de los estados solicitan su número de teléfono por si tienen preguntas sobre su solicitud. Sin embargo, **no** tiene obligación de llenar esta casilla.

Casilla 6 – Número de identificación
La ley federal requiere que los estados obtengan un número de identificación de todos los que se inscriben para votar. Consulte las instrucciones específicas de su estado para el número 6 sobre qué número es aceptable en su estado. Si no tiene ni licencia de manejar ni número de Seguro Social, indíquelo en este formulario y su estado le asignará un número.

Casilla 7 – Selección de partido político
En algunos estados se tiene que inscribir en un partido político si desea participar en las elecciones primarias, en la asamblea local (caucus) o en la convención de ese partido político. Para determinar si su estado requiere esta inscripción, vea el número 7 en las instrucciones correspondientes a su estado.

Si se quiere inscribir en un partido político, escriba en letras de molde en la casilla el nombre completo del partido que prefiere.

Si **no** desea inscribirse en un partido, escriba "no party" (ningún partido) o deje la casilla en blanco. **No** escriba la palabra "independent" (independiente) si quiere significar "no party" (ningún partido), porque se lo puede confundir con un partido político de su estado.
Nota: Si se inscribe sin indicar un partido político, aún puede votar en las elecciones generales y en las elecciones primarias no partidarias (que no son específicas de un partido político).

Casilla 8 – Raza o grupo étnico
Algunos estados le preguntan cuál es su raza o grupo étnico, para administrar la Ley Federal de Derechos del Votante. Para averiguar si su estado solicita esta información, vea el número 8 en las instrucciones correspondientes a su estado. En caso afirmativo, escriba en la Casilla 8 la opción que mejor lo describa de la lista a continuación:

- Indígena norteamericano o nativo de Alaska
- Asiático o isleño del Pacífico
- Negro, *no de* origen hispano
- Hispano
- Multirracial
- Blanco, *no de* origen hispano
- Otro

Casilla 9 – Firma
Lea la información en el número 9 de las instrucciones de su estado. Antes de firmar o hacer su marca, verifique que:

(1) cumple con los requisitos de su estado y que
(2) entiende **todo** lo que dice en la Casilla 9.

Finalmente, firme su nombre **completo** o ponga su marca y escriba claramente la fecha de hoy en este orden: mes, día, año. Si el solicitante no puede firmar, ponga en la **Casilla D** el nombre completo, la dirección y el número de teléfono (opcional) de la persona que ayudó al solicitante.

Solicitud de Inscripción de Votante

Before completing this form, review the General, Application, and State specific instructions.
Antes de llenar este formulario, vea las instrucciones generales, las instrucciones para llenar esta solicitud, y las instrucciones específicas de su estado.
PLEASE PROVIDE YOUR RESPONSES IN ENGLISH. / PROPORCIONE SUS RESPUESTAS EN INGLÉS.

Are you a citizen of the United States of America? / ¿Es usted ciudadano de Estados Unidos de América? ☐ Will you be 18 years old on or before election day? / ¿Habrá cumplido los 18 años de edad para el día de las elecciones? ☐

If you check "No" in response to either of these questions, do not complete form.
Si contestó "No" a alguna de estas preguntas, no llene el formulario.
(Please see state-specific instructions for rules regarding eligibility to register prior to age 18.)
(Vea también las instrucciones específicas de su estado sobre la posibilidad de inscribirse antes de los 18 años de edad.)

This space for office use only. / Este espacio sólo para uso de la oficina.

1		Last Name / Apellido	First Name / Primer nombre	Middle Name(s) / Segundo nombre	
2	Home Address / Dirección donde vive		Apt. or Lot # / Nº. de depto. o lote	City/Town / Ciudad/Localidad	State / Estado	Zip Code / Código postal
3	Address Where You Get Your Mail If Different From Above / Dirección donde recibe su correo, si es diferente a la de más arriba			City/Town / Ciudad/Localidad	State / Estado	Zip Code / Código postal

4	Date of Birth/ Fecha de nacimiento Month / Mes Day / Día Year / Año	5	Telephone Number (optional) / Número de teléfono (optativo)	6	ID Number (See Item 6 in the instructions for your state) / Número de identificación (Vea el número 6 en las instrucciones de su estado)
7	Choice of Party (see item 7 in the instructions for your State) / Selección de partido político (Vea el número 7 en las instrucciones de su estado)	8	Race or Ethnic Group (see item 8 in the instructions for your State) / Raza o grupo étnico (Vea el número 8 en las instrucciones de su estado)		

9 I have reviewed my state's instructions and I swear/affirm that: / Leí las instrucciones de mi estado y juro/afirmo que:

- I am a United States citizen. / Soy ciudadano de Estados Unidos.
- I meet the eligibility requirements of my state and subscribe to any oath required. / Cumplo con los requisitos de mi estado y presto cualquier juramento requerido.
- The information I have provided is true to the best of my knowledge under penalty of perjury. If I have provided false information, I may be fined, imprisoned, or (if not a U.S. citizen) deported from or refused entry to the United States. / La información que proporcioné es verdadera según mis mejores conocimientos, bajo pena de perjurio. Si proporcioné información falsa, se me puede multar, encarcelar o (si no soy ciudadano de EE UU), deportar de o denegar entrada a Estados Unidos.

Please sign full name (or put mark) / Firme su nombre completo (o ponga su marca) ▲

Date / Fecha: ____ / ____ / ____
Month / Mes Day / Día Year / Año

If you are registering to vote for the first time: please refer to the application instructions for information on submitting copies of valid identification documents with this form.
Si se está inscribiendo para votar por primera vez: consulte las instrucciones de la solicitud para información sobre presentar copias documentos de identificación válidos con este formulario.

Please fill out the sections below if they apply to you.
Llene las secciones a continuación que correspondan a su situación.

If this application is for a **change of name**, what was your name before you changed it? / Si esta solicitud es para un **cambio de nombre**, ¿cómo se llamaba antes de cambiar de nombre?

A		Last Name / Apellido	First Name / Primer nombre	Middle Name(s) / Segundo nombre	

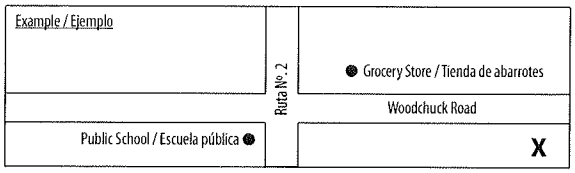
If you were **registered before but this is the first time you are registering from the address in Box 2**, what was your address where you were registered before?
Si estuvo **inscrito antes, pero esta es la primera vez que se está inscribiendo con la dirección en la Casilla 2**, ¿cuál era la dirección con que estaba inscrito antes?

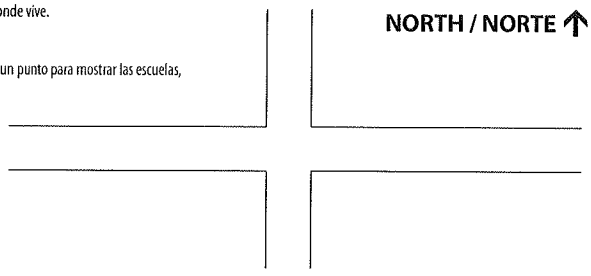
B	Street (or route and box number) / Calle (o número de ruta y casilla)	Apt. or Lot # / Nº. de depto. o lote	City/Town/County / Ciudad/Localidad/Condado	State / Estado	Zip Code / Código postal

If you live in a rural area but do not have a street number, or if you have no address, please show on the map where you live.
Si vive en una zona rural, pero no tiene un número de calle, o si no tiene dirección, muestre en el mapa dónde vive.

C

- Write in the names of the crossroads (or streets) nearest to where you live. / Escriba el nombre de las calles que cruzan más cerca de donde vive.
- Draw an X to show where you live. / Ponga una X para mostrar el lugar en que vive.
- Use a dot to show any schools, churches, stores, or other landmarks near where you live, and write the name of the landmark. /Ponga un punto para mostrar las escuelas, iglesias, tiendas u otros puntos de referencia y escriba el nombre del punto de referencia.





If the applicant is unable to sign, who helped the applicant fill out this application? Give name, address and phone number (phone number optional).
Si el solicitante no puede firmar, ¿quién ayudó al solicitante a llenar esta solicitud? Dé el nombre, la dirección y el número de teléfono. (El número de teléfono es optativo).

D

Mail this application to the address provided for your State.
Envíe esta solicitud a la dirección provista por su estado.

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FIRST CLASS STAMP NECESSARY FOR MAILING

Print Application

Voter Registration Application/Solicitud de Inscripción de Votante

Before completing this form, review the General, Application, and State specific instructions.
Antes de llenar este formulario, vea las instrucciones generales, las instrucciones para llenar esta solicitud, y las instrucciones específicas de su estado.
PLEASE PROVIDE YOUR RESPONSES IN ENGLISH. / PROPORCIONE SUS RESPUESTAS EN INGLÉS.

Are you a citizen of the United States of America? ☐ Yes ☐ No
¿Es usted ciudadano de Estados Unidos de América? Sí No

Will you be 18 years old on or before election day? ☐ Yes ☐ No
¿Habrá cumplido los 18 años de edad para el día de las elecciones? Sí No

If you check "No" in response to either of these questions, do not complete form.
Si contestó "No" a alguna de estas preguntas, no llene el formulario.
(Please see state-specific instructions for rules regarding eligibility to register prior to age 18.)
(Vea también las instrucciones específicas de su estado sobre la posibilidad de inscribirse antes de los 18 años de edad).

This space for office use only. / Este espacio sólo para uso de la oficina.

1	(Circle one) / (Marque uno con un círculo) Mr. / Sr. Mrs. / Sra. Miss / Sta. Ms. / Sra.	Last Name / Apellido	First Name / Primer nombre	Middle Name(s) / Segundo nombre	(Circle one) / (Marque uno con un círculo) Jr. Sr. II III IV
2	Home Address / Dirección donde vive	Apt. or Lot # / Nº. de depto. o lote	City/Town / Ciudad/Localidad	State / Estado	Zip Code / Código postal
3	Address Where You Get Your Mail If Different From Above / Dirección donde recibe su correo, si es diferente a la de más arriba		City/Town / Ciudad/Localidad	State / Estado	Zip Code / Código postal

4	Date of Birth/ Fecha de nacimiento Month / Mes Day / Día Year / Año	5	Telephone Number (optional) / Número de teléfono (optativo)	6	ID Number (See Item 6 in the instructions for your state) / Número de identificación (Vea el número 6 en las Instrucciones de su estado)
7	Choice of Party (see item 7 in the instructions for your State) / Selección de partido político (Vea el número 7 en las instrucciones de su estado)	8	Race or Ethnic Group (see item 8 in the instructions for your State) / Raza o grupo étnico (Vea el número 8 en las instrucciones de su estado)		

9 I have reviewed my state's instructions and I swear/affirm that: / Leí las instrucciones de mi estado y juro/afirmo que:
- I am a United States citizen. / Soy ciudadano de Estados Unidos.
- I meet the eligibility requirements of my state and subscribe to any oath required. / Cumplo con los requisitos de mi estado y presto cualquier juramento requerido.
- The information I have provided is true to the best of my knowledge under penalty of perjury. If I have provided false information, I may be fined, imprisoned, or (if not a U.S. citizen) deported from or refused entry to the United States. / La información que proporcioné es verdadera según mis mejores conocimientos, bajo pena de perjurio. Si proporcioné información falsa, se me puede multar, encarcelar o (si no soy ciudadano de EE UU), deportar de o denegar entrada a Estados Unidos.

Please sign full name (or put mark) / Firme su nombre completo (o ponga su marca) ▲

Date / Fecha: ____ / ____ / ____
Month / Mes Day / Día Year / Año

If you are registering to vote for the first time: please refer to the application instructions for information on submitting copies of valid identification documents with this form.
Si se está inscribiendo para votar por primera vez: consulte las instrucciones de la solicitud para información sobre presentar copias documentos de identificación válidos con este formulario.

Please fill out the sections below if they apply to you.
Llene las secciones a continuación que correspondan a su situación.

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A	Mr. / Sr. Mrs. / Sra. Miss / Sta. Ms. / Sra.	Last Name / Apellido	First Name / Primer nombre	Middle Name(s) / Segundo nombre	(Circle one) / (Marque uno con un círculo) Jr. Sr. II III IV

If you were **registered before but this is the first time you are registering from the address in Box 2**, what was your address where you were registered before?
Si estuvo **inscrito antes, pero esta es la primera vez que se está inscribiendo con la dirección en la Casilla 2**, ¿cuál era la dirección con que estaba inscrito antes?

B	Street (or route and box number) / Calle (o número de ruta y casilla)	Apt. or Lot # / Nº. de depto. o lote	City/Town/County / Ciudad/Localidad/Condado	State / Estado	Zip Code / Código postal

If you live in a rural area but do not have a street number, or if you have no address, please show on the map where you live.
Si vive en una zona rural, pero no tiene un número de calle, o si no tiene dirección, muestre en el mapa dónde vive.

C
- Write in the names of the crossroads (or streets) nearest to where you live. / Escriba el nombre de las calles que cruzan más cerca de donde vive.
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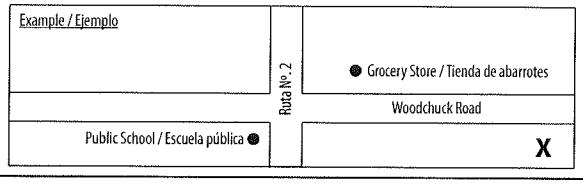

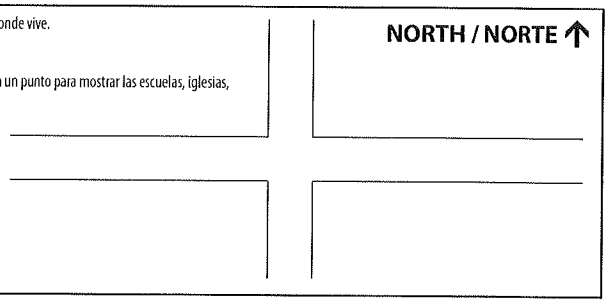

If the applicant is unable to sign, who helped the applicant fill out this application? Give name, address and phone number (phone number optional).
Si el solicitante no puede firmar, ¿quién ayudó al solicitante a llenar esta solicitud? Dé el nombre, la dirección y el número de teléfono. (El número de teléfono es optativo).

D

Mail this application to the address provided for your State.
Envíe esta solicitud a la dirección provista por su estado.

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7. Selección de partido político. Si está inscrito en un partido político calificado para ser reconocido en la papeleta, se le permitirá que vote en las elecciones primarias de ese partido político. Si está inscrito como independiente, sin preferencia de partido político o cómo miembro de un partido político no calificado para ser reconocido en la papeleta, puede elegir y votar una papeleta de elección primaria de uno de los partidos políticos reconocidos.
8. Raza o grupo étnico. Deje en blanco.
9. Firma. Para inscribirse en Arizona tiene que:
• ser ciudadano de Estados Unidos
• ser residente de Arizona y de su condado al menos 29 días antes de las próximas elecciones
• haber cumplido los 18 años de edad antes de las próximas elecciones generales
• no haber sido condenado de traición a la patria ni de un delito grave (o haberle sido restituidos sus derechos civiles)
• no estar declarado actualmente cómo una persona incapacitada por ningún tribunal de justicia

Dirección postal:
Secretary of State/Elections
1700 W. Washington, 7th Floor
Phoenix, AZ 85007-2888

Arkansas

Revisado: 01-03-2006

Fecha límite de inscripción — 30 días antes de las elecciones.

6. Número de identificación. Su formulario de inscripción de votante debe contener el número de su licencia de conducir del estado o el número de identificación de los no conductores emitido por el estado. Si no tiene una licencia de conducir ni identificación de no conductor, tiene que incluir las últimas cuatro cifras de su número del Seguro Social. Si *no tiene* una licencia de conducir, ni una licencia de identificación de no conductor, ni un número del Seguro Social, escriba "NONE" (NINGUNO) en el formulario. El secretario de estado le asignará un número.
7. Selección de partido político. Opcional. No tiene obligación de inscribirse en un partido político si no desea participar en las elecciones primarias, en la asamblea local (caucus) o en la convención de un determinado partido político.
8. Raza o grupo étnico. Deje en blanco.
9. Firma. Para inscribirse en Arkansas tiene que:
• ser ciudadano de Estados Unidos
• vivir en Arkansas en la dirección indicada en la Casilla 2 de la solicitud
• haber cumplido los 18 años de edad antes de las próximas elecciones
• no haber sido condenado de un delito grave (a menos que haya cumplido completamente su sentencia o que lo hayan perdonado)
• no reclamar derecho a votar en ninguna otra jurisdicción
• no haber sido declarado anteriormente mentalmente incompetente por un tribunal con la debida jurisdicción

Dirección postal:
Secretary of State
Voter Services
P.O. Box 8111
Little Rock, AR 72203-8111

California

Revisado: 01-03-2006

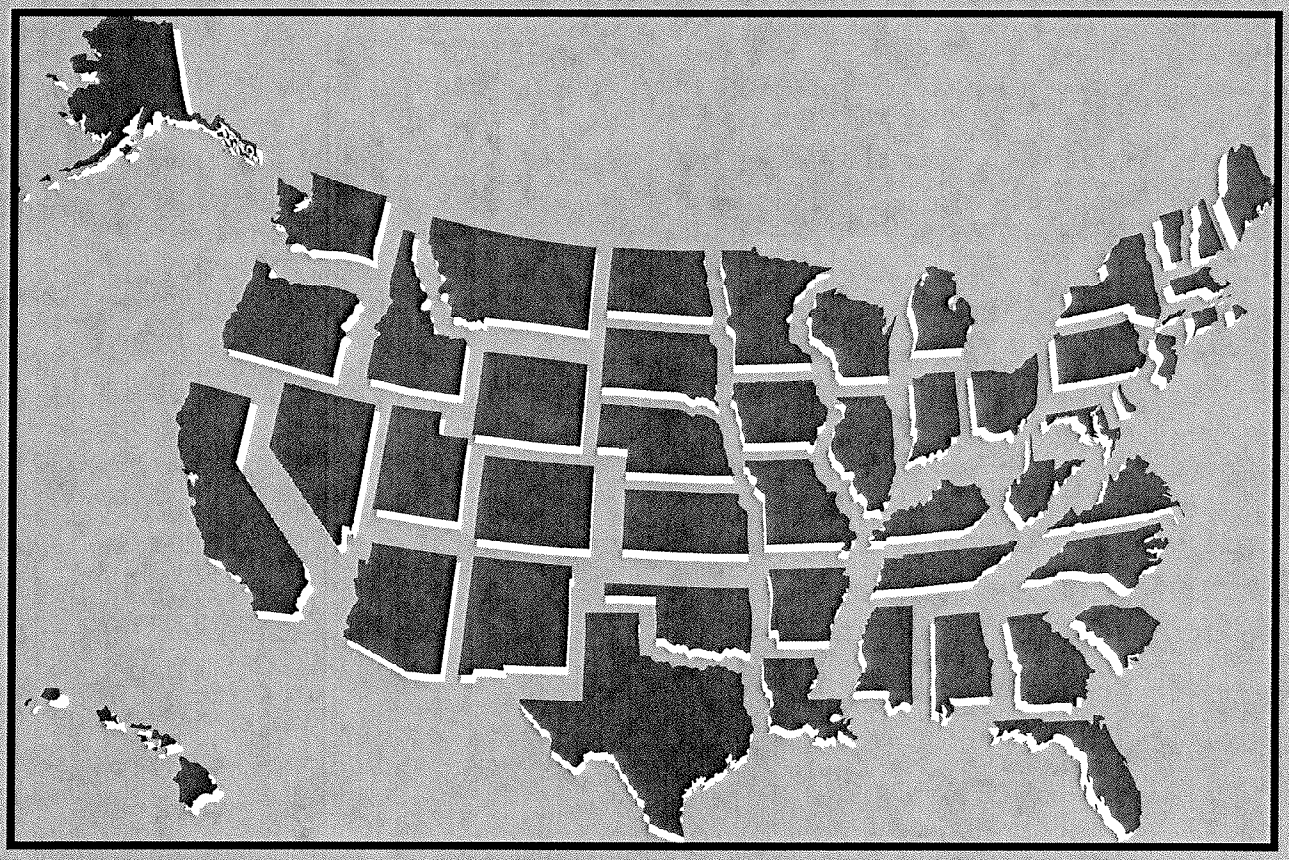
Fecha límite de inscripción — 15 días antes de las elecciones.

6. Número de identificación. Cuando se inscribe para votar tiene que proporcionar el número de su licencia de conducir de California o el número de la tarjeta de identificación de California, si tiene alguna. Si no tiene ni licencia de conducir, ni tarjeta de identificación, tiene que dar las últimas cuatro cifras de su número del Seguro Social (SSN). Si no incluye esta información, tendrá que proporcionar identificación cuando vote.
7. Selección de partido político. Escriba el nombre del partido político en el que se desea inscribir. Si no se quiere inscribir en ningún partido, ponga "Decline to state" (No deseo indicar) en el espacio provisto. La ley de California permite que los votantes que "no desean indicar" una afiliación a un partido político calificado, o que se afilian a un partido político no calificado, voten en las elecciones primarias de cualquier partido político calificado que haya sometido una notificación ante el secretario de estado permitiéndole hacerlo. Puede llamar al 1-800-345-VOTE o visitar www.sos.ca.gov para averiguar qué partidos políticos están permitiendo que votantes no afiliados participen en sus elecciones primarias.
8. Raza o grupo étnico. Deje en blanco.
9. Firma. Para inscribirse en California tiene que:
• ser ciudadano de Estados Unidos
• ser residente de California
• tener al menos 18 años de edad en la fecha de las próximas elecciones
• no estar preso ni bajo libertad supervisada por haber sido condenado de un delito grave
• no haber sido juzgado mentalmente incompetente por ningún tribunal

Se requiere firma. Si cumple con los requisitos indicados más arriba, firme y feche la tarjeta de inscripción en el espacio provisto.

Dirección postal:
Secretary of State
Elections Division
1500 11th Street
Sacramento, CA 95814

Magrehistro upang Makaboto sa Iyong Estado sa Pamamagitan nitong Postcard Form at Gabay



Para sa mga Mamamayan ng Estados Unidos

Pangkalahatang Mga Tagubilin

Sino ang Makakagamit ng Aplikasyong ito
Kung ikaw ay isang mamamayan ng Estados Unidos na naninirahan o may address sa loob ng Estados Unidos, maaari mong gamitin ang aplikasyon sa libritong ito:

- upang makaboto sa iyong Estado,
- I-ulat ang pagpapalit ng pangalan sa iyong tanggapan para sa rehistrasyon ng botante,
- I-ulat ang pagpapalit ng address sa iyong tanggapan para sa rehistrasyon ng botante, o
- Para maka-rehistro sa isang partidong pulitikal.

Mga Eksepsyon
Mangyari lamang na huwag gamitin ang aplikasyong ito kung ikaw ay nakatira sa labas ng Estados Unidos at mga teritoryo nito at walang (legal) na address ng tirahan sa bansang ito, *o* kung ikaw ay isang militar na nakadestino malayo sa iyong tirahan. Gamitin ang Federal Postcard Application na mula sa mga base militar, mga embahada ng Amerika, o mga tanggapan ng konsulado.

Tatanggapin ng mga kawani ng mga lungsod at bayan ng **New Hampshire** ang aplikasyong ito bilang isang kahilingan lamang para sa kanilang sariling dokumento para sa rehistrasyon ng botanteng hindi makakarating na maghuhulog ng balota sa koreo. Ang **North Dakota** ay hindi magsasagawa ng rehistrasyon ng botante. Hindi pinapahintulutan ayon sa batas ng **Wyoming** ang pagrehistro gamit ang koreo.

Paano Malalaman Kung Ikaw ay Kuwalipikado Upang Makaboto sa Iyong Estado
Ang bawat Estado ay mayroong mga batas ukol sa kung sinu-sino ang maaaring bumoto. Tingnan ang impormasyong nakatala sa ilalim ng iyong Estado sa Mga Tagubilin ng Estado. Hinihiling ng lahat ng mga Estado na ikaw ay isang mamamayan ng Estados Unidos ayon sa kapanganakan o naturalisasyon upang makapagrehistro at makaboto sa mga halalang pederal at halalan ng estado. Ipinagbabawal ng Batas Pederal ang maling pag-aangkin ng pagiging mamamayan ng Estados Unidos para magrehistro upang makaboto sa kahit na anong halalang pederal, ng estado, o panlokal. **Hindi** ka maaaring magrehistro para magboto higit sa isang lugar at higit sa isang beses.

Paano Kumpletuhin ang Aplikasyong Ito
Gamiting pareho ang Mga Tagubilin sa Aplikasyon at Mga Tagubilin ng Estado bilang iyong gabay sa pagsusulat ng aplikasyon.

- Simula, basahin ang Mga Tagubilin ng Aplikasyon. Ang mga tagubiling ito ay magbibigay sa iyo ng mahahalagang impormasyon na nauukol sa lahat ng gumagamit ng aplikasyong ito.
- Sumunod, hanapin ang iyong Estado sa ilalim ng Mga Tagubilin ng Estado. Gamitin ang mga tagubiling ito upang punan ang mga Kahon 6,7, at 8. umangguni rin sa mga tagubilin na ito para sa impormasyong ukol sa botante at kahit na anong panunumpang hinihiling sa Kahon 9.
- **MANGYARI LAMANG NA IBIGAY ANG IYONG MGA KASAGUTAN SA INGLES.**

Kailan dapat Magrehistro upang Makaboto
Ang bawat Estado ay may sariling huling takdang araw para sa pagpaparehistro upang makaboto. Tingnan ang huling takdang araw para sa iyong Estado sa huling pahina ng libritong ito.

Paano I-sumite ang Iyong Aplikasyon
Ipadala sa koreo ang iyong aplikasyon sa address na nakalista sa ilalim ng iyong Estado sa Mga Tagubilin ng Estado.
O, personal na dalhin ang aplikasyon sa iyong lokal na tanggapan ng rehistrasyon ng botante. Ang mga Estado na obligadong tanggapin ang pambansang form ay tatanggap ng mga kopya ng aplikasyon na nalimbag mula sa imahe ng computer sa karaniwang naka-imbak na dokumento, na nilagdaan ng aplikante, at inihulog sa koreo sa isang sobre na may wastong bayad sa selyo.

Mga Botanteng mapasa-Unang Pagkakataong Nagrehistro sa Pamamagitan ng Koreo
Kung ang aplikasyon ng rehistrasyon na ito ay ang iyong unang pagkakataong bumoto sa pamamagitan ng koreo, hinihiling mula sa iyo ng Batas Pederal na magpakita ng katibayan sa unang pagkakataon na ikaw ay bumoto. Katunayan ng pagkakakilanlan ay kinabibilangan ng:

- Isang kasalukuyang at balidong litrato ng pagkakakilanlan o
- Isang pangkasalukuyang kahilingan ng bayad serbisyong pampubliko (kuryente, tubig, gas), bank statement, tseke ng gobyerno, paycheck o dokumento ng gobyerno na ipinapakita ang iyong pangalan at address.

Maaari ligtas ang mga botante mula sa kahilingang ito kung sila ay mag-sumite ng isang **KOPYA** ng pagkakakilanlang ito kasama ng kanilang dokumento para sa rehistrasyon ng botanteng magboboto pala-koreo. Kung nais mong mag-sumite ng **KOPYA**, mangyari lamang na tandaan ang mga sumusunod:

- Maaaring may mga karagdagang kahilingan para sa pagkakakilanlan ang iyong estado. At kakailanganing sa iyo na magpakita ng pagkakakilanlan sa botohan kahit na matugunan mo ang Pederal na katibayan ng pagkakakilanlan.
- Huwag i-sumite ang orihinal na mga dokumento kasama ng aplikasyon na ito, ngunit ang mga **KOPYA** lamang.

Kung Ibinigay sa Iyo ang Aplikasyon na ito sa Tanggapan ng Estado o Himpilan ng Gobyerno
Kung ibinigay sa iyo ang aplikasyon na ito sa isang ahensya ng Estado o himpilan ng gobyerno, nasasa-iyo ang desisyon na gamitin ang aplikasyon na ito. Kung mapagpasyahan mo na gamitin ang aplikasyon na ito upang makaboto, maaari mo itong punan at iwanan sa ahensya ng Estado o himpilan ng gobyerno. Isu-sumite ang aplikasyon para sa iyo.
O, maaari mo itong ihulog sa koreo sa address na nakalista sa ilalim ng iyong Estado sa Mga Tagubilin ng Estado. Maaari mo rin itong dalhin upang ibigay ng personal sa iyong lokal na tanggapan para sa rehistrasyon ng botante.
Tandaan: Ang pangalan at lokasyon ng ahensya ng Estado o himpilan ng gobyerno kung saan mo natanggap ang aplikasyon ay mananatiling kompidensyal. Hindi ito ipapakita sa iyong aplikasyon. At, kung magpasya ka na huwag gamitin ang aplikasyon na ito upang makaboto, ang desisyon na iyon ay mananatiling kompidensyal. Hindi ito makaka-apekto sa serbisyong iyong matatanggap mula sa ahensya o himpilan.

Mga Tagubulin sa Aplikasyon

Bago sulatan ang nilalaman ng form, mangyari lamang na sagutin ang mga katanungan sa itaas ng form kung ikaw ay isang mamamayan ng Estados Unidos at kung ikaw ay may edad na 18 taong gulang sa pagsapit o bago ang Araw ng Halalan. Kung ang iyong sagot ay hindi sa kahit na alin sa mga katanungan na ito, hindi mo maaaring gamitin ang form na ito upang magrehistro para makaboto. Gayunman, ang mga tiyak na tagubilin ng estado ay nagkakaloob ng karagdagang mga impormasyon para makaboto bago sumapit ng edad na 18.

Kahon 1 — Pangalan
Ilagay sa kahong ito ang iyong buong pangalan sa ganitong paraan ng pagkakasunod-sunod — Apelyido, Pangalan, Gitnang Pangalan. Huwag gumamit ng mga palayaw o inisyal. *Tandaan:* Kung ang aplikasyong ito ay para sa isang pagpapalit ng pangalan, mangyari lamang na sabihin sa amin sa **Kahon A** *(sa kalahati ng form)* ang iyong buong pangalan bago mo ito ibago.

Kahon 2 — Address ng Tirahan
Ilagay sa kahong ito ang address ng iyong tirahan (legal na address) **Huwag** ilagay ang iyong address pang-koreo kung ito ay iba sa iyong address ng tirahan. **Huwag** gumamit ng post office box o rural route na walang box number. Sumangguni sa mga tagubilin na tiyak sa estado para sa mga patakaran hinggil sa paggamit ng mga route number.

Tandaan: Kung ikaw ay nakarehistro dati *ngunit* ito ang unang pagkakataon na ikaw ay nagparehistro mula sa address sa Kahon 2, mangyari lamang na sabihin sa amin sa **Kahon B** *(sa ibabang bahagi ng form)* ang address kung saan ka nakarehistro dati. Mangyari lamang na ibigay sa amin ang lubos ng iyong makakayanang matandaan ukol sa address.

Tandaan Din: Kung ikaw ay nakatira sa isang rural na lugar ngunit walang address ng kalye, *o* wala kang address, mangyari lamang na ipakita sa amin kung saan ka nakatira sa pamamagitan ng mapa sa **Kahon C** *(sa ibaba ng form).*

Kahon 3 — Address Pang-Koreo
Kung nakukuha mo ang iyong mga liham sa isang address na kaiba mula sa address sa Kahon 2, mangyari lamang na ilagay ang iyong address pang-koreo sa kahon na ito. Kung wala kang address sa Kahon 2, **kailangan** mong isulat sa Kahon 3 ang address kung saan maaaring makipag-ugnayan sa iyo sa pamamagitan ng koreo.

Kahon 4 — Petsa ng Kapanganakan
Ilagay sa kahon na ito ang iyong petsa ng kapanganakan sa ganitong paraan ng pagkakasunod-sunod — Buwan, Araw, Taon. *Mag-ingat at huwag gamitin ang petsa ngayon!*

Kahon 5 — Numero ng Telepono
Ang karamihan sa mga Estado ay hihingi ng iyong numero ng telepono sa kaganapan na may mga katanungan tungkol sa iyong aplikasyon. Gayunman, **hindi** mo kailangan punan ang kahon na ito.

Kahon 6 — Numero ng ID
Hinihiling ng Batas Pederal na likumin ng mga estado mula sa bawat nagpaparehistro ang isang numero ng pagkakakilanlan. Kailangan mong sumangguni sa mga tagubilin na tiyak sa estado para sa ika-6 na bagay hinggil sa impormasyon kung aling numero ang tinatanggap sa iyong estado. Kung mayroon kang lisensya sa pagmamaneho o numerong pang-social security, mangyari lamang na ipahiwatig ito sa form at magtatalaga ng isang numero para sa iyo ang estado.

Kahon 7 — Pagpili ng Partido
Sa ilang mga Estado, kailangan mong magrehistro sa isang partido kung nais mong maging bahagi sa halalang primarya, pagpupulong, o kombensiyon ng partido. Upang malaman kung hinihiling ito ng iyong Estado, tingnan ang ika-7 bagay sa tagubilin sa ilalim ng iyong Estado.

Kung nais mong magrehistro sa isang partido, i-print sa kahon ang buong pangalan ng partido na iyong pinipili.

Kung **hindi** mo nais na magparehistro sa isang partido, isulat ang "walang partido" o iwanang blangko ang kahon. **Huwag** isulat ang salitang "idependiyente" kung ang nais mong sabihin ay "walang partido", dahil marahil na ikalilito ito sa pangalan ng partidong pulitikal sa iyong Estado.
Tandaan: Kung hindi ka magparehistro sa isang partido, maaari ka pa ring bumoto sa pangkalahatang halalan at walang pinapanigan (nonparty) na halalang primarya.

Kahon 8 — Lahi o Grupong Etniko
Ang ilang mga Estado ay humihingi ng iyong lahi o grupong etniko, para mapangasiwa ang Batas hinggil sa Karapatan sa Pagboboto ng Bansa (Federal Voting Rights Act). Upang malaman kung hinihiling ang impormasyong ito ng iyong Estado, tingnan ang ika-8 na bagay sa tagubilin sa ilalim ng iyong Estado. Kung gayon, ilagay sa Kahon 8 ang napiling pinakamainam para sa iyo mula sa listahan sa ibaba:

- American Indian *o* Katutubong Taga-Alaska
- Asyano o Pacific Islander
- Black, *hindi* nagmula sa Hispaniko Pinagmulan
- Hispaniko
- Iba't ibang mga lahi
- White, *hindi* nagmula sa Hispaniko Pinagmulan
- Iba pa

Kahon 9 — Lagda
Repasuhin ang impormasyon sa ika-9 na bagay sa mga tagubilin sa iyong Estado. Bago mo lagdaan o isulat ang iyong marka, tiyakin na:

(1) Natutugunan mo ang mga kahilingan ng iyong Estado, at
(2) Nauunawaan mo ang **lahat** ng nasa Kahon 9.

Bilang panghuli, ilagda ang iyong **buong** pangalan o ilagay ang iyong marka, at i-print ang petsa ngayong araw sa ganitong uri ng pagkakasunod-sunod — Buwan, Araw, Taon. Kung hindi makakayanang lumagda ng aplikante, ilagay sa **Kahon D** ang pangalan, address, at numero ng telepono (opsyonal) ng tao na tumulong sa aplikante.

Voter Registration Application/Aplikasyon sa Pagrehistro ng Botante

Before completing this form, review the General, Application, and State specific instructions.
Bago kumpletuhin ang form na ito, irepaso ang Pangkalahatan, Aplikasyon, at tiyak sa Estado na mga tagubilin.
PLEASE PROVIDE YOUR RESPONSES IN ENGLISH. / MANGYARI LAMANG NA IBIGAY ANG IYONG MGA KASAGUTAN SA INGLES.

Are you a citizen of the United States of America? / Ikaw ba ay isang mamamayan ng Estados Unidos? [ ]
Will you be 18 years old on or before election day? / Ikaw ba ay may edad na 18 taong gulang sa pagsapit o bago ang araw ng halalan. [ ]
If you check "No" in response to either of these questions, do not complete form.
Kung nilagyan mo ng tsek ang "Hindi" bilang sagot sa kahit alin sa mga katanungan na ito, huwag kumpletuhin ang form.
(Please see state-specific instructions for rules regarding eligibility to register prior to age 18.)
(Mangyari lamang na tingnan ang mga tiyak sa estado na mga tagubilin para sa mga patakaran hinggil sa bago sumapit sa edad na 18 taong gulang.)

This space for office use only. / Ang espasyo ito ay para sa gamit ng tanggapan lamang.

1		Last Name / Apelyido	First Name / Pangalan	Middle Name(s) / (Mga)Gitnang Pangalan	
2	Home Address / Address ng Tirahan	Apt. or Lot # / Apt. o Lot #	City/Town / Lungsod/Bayan	State / Estado	Zip Code
3	Address Where You Get Your Mail If Different From Above / Address Kung Saan Mo Natatanggap ang Iyong Mga Sulat Kung Iba Mula sa Itaas		City/Town / Lungsod/Bayan	State / Estado	Zip Code

4	Date of Birth/ Petsa ng Kapanganakan ___ / ___ / ___ Month / Buwan Day / Araw Year / Taon	5	Telephone Number (optional) / Numero ng Telepono (opsyonal)	6	ID Number (See Item 6 in the instructions for your state) / Numero ng ID (Tingnan ang Ika-6 na Bagay sa mga tagubilin para sa iyong estado)
7	Choice of Party (see item 7 in the instructions for your State) / Pinipiling Partido (tingnan ang Ika-7 na bagay sa mga tagubilin para sa iyong estado)	8	Race or Ethnic Group (see item 8 in the instructions for your State) / Lahi o Grupong Etniko (tingnan ang Ika-8 na bagay sa mga tagubilin para sa iyong Estado)		

9 I have reviewed my state's instructions and I swear/affirm that: /
Aking narepaso ang mga tagubilin ng aking estado at aking isinusumpa/pinapatotohanan na:

- I am a United States citizen / Ako ay isang mamamayan ng Estados Unidos
- I meet the eligibility requirements of my state and subscribe to any oath required. / Natutugunan ko ang mga hinihiling kwalipikasyong at sa pumapatnubay ako kahit na anong panunumpa na kinakailangan.
- The information I have provided is true to the best of my knowledge under penalty of perjury. If I have provided false information, I may be fined, imprisoned, or (if not a U.S. citizen) deported from or refused entry to the United States. / Ang impormasyon na aking ipinagkaloob ay totoo sa lubos ng aking kaalaman sa ilalim ng kaparusahan ng panunumpang huwad. Kung ako ay nagkaloob ng hindi totoong impormasyon, ako ay maaring patawan ng multa, pagkakakulong, o (kung hindi mamamayan ng Estados Unidos) pagbabalik sa bansang pinanggalingan mula sa o tatanggihan ng pagpasok sa Estados Unidos.

Please sign full name (or put mark) / Mangyari lamang na ilagda ang buong pangalan (o lagyan ng marka) ▲

Date / Petsa: ___ / ___ / ___
Month /Buwan Day / Araw Year / Taon

If you are registering to vote for the first time: please refer to the application instructions for information on submitting copies of valid identification documents with this form.
Kung ikaw ay nagpaparehistro para makaboto sa unang pagkakataon: mangyari lamang na sumangguni sa mga tagubilin sa aplikasyon para sa impormasyon sa pagsusumite ng mga kopya ng balidong dokumento ng pagkakakilanlan kasama ng form na ito.

Please fill out the sections below if they apply to you.
Mangyari lamang na sulatan ang mga seksyon sa ibaba kung ang mga ito ay naaangkop sa iyo.

If this application is for a **change of name**, what was your name before you changed it? / Kung ang aplikasyon na ito ay para sa **pagpapalit ng pangalan**, ano ang iyong pangalan bago mo ito palitan.

A		Last Name / Apelyido	First Name / Pangalan	Middle Name(s) / (Mga)Gitnang Pangalan	

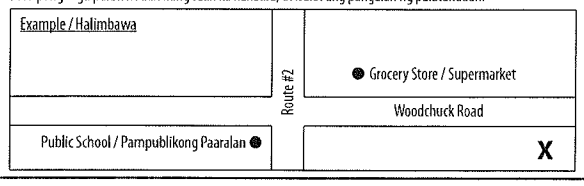
If you were **registered before but this is the first time you are registering from the address in Box 2**, what was your address where you were registered before?
Kung ikaw ay **nakarehistro dati ngunit ito ang unang pagkakataon na ikaw ay nagparehistro mula sa address sa Kahon 2**, ano ang address kung saan ka nakarehistro dati?

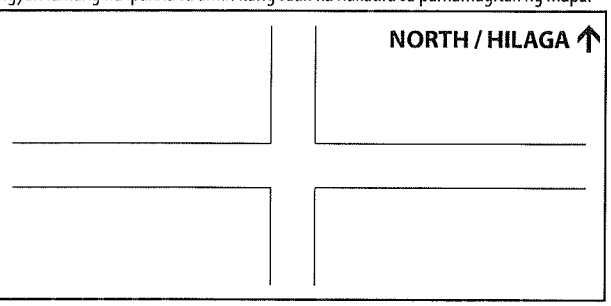
B	Street (or route and box number) / Kalye (o route at box numer)	Apt. or Lot # / Apt. o Lot #	City/Town/County / Lungsod/Bayan/County	State / Estado	Zip Code

If you live in a rural area but do not have a street number, or if you have no address, please show on the map where you live.
Kung ikaw ay nakatira sa isang rural na lugar ngunit walang numero ang kalye, o wala kang address, mangyari lamang na ipakita sa amin kung saan ka nakatira sa pamamagitan ng mapa.

C

- Write in the names of the crossroads (or streets) nearest to where you live. / Isulat ang mga pangalan ng kanto (o kalye) na pinakamalapit kung saan ka nakatira.
- Draw an X to show where you live. / Sulatan ng X upang ipakita kung saan ka nakatira.
- Use a dot to show any schools, churches, stores, or other landmarks near where you live, and write the name of the landmark. / Gumamit ng tuldok upang ipakita ang kahit na anong mga paaralan, mga simbahan, mga tindahan, o iba pang mga palatandaan kung saan ka nakatira, at isulat ang pangalan ng palatandaan.





If the applicant is unable to sign, who helped the applicant fill out this application? Give name, address and phone number (phone number optional).
Kung hindi makakalagda ang aplikante,sino ang tumulong sa aplikante na sulatan ang aplikasyon na ito? Ibigay ang pangalan, address at numero ng telepono (opsyonal ang numero ng telepono).

D

Mail this application to the address provided for your State.
Ihulog sa koreo ang aplikasyon na ito sa address na ipinagkaloob para sa iyong Estado.

Pinabago 10/29/2003

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FIRST CLASS STAMP NECESSARY FOR MAILING

Print Application

iyong numero ng social security kung may ipinalabas sa iyo. Kung ikaw ay walang pangkasalukuyan at balidong lisensya sa pangmaneho o hindi ipinapangasiwa na lisensya ng pagkakakilanlan o isang numero ng social security, mangyari lamang na isulat ang "WALA" sa form. Isang bukod-tanging numero ang itatalaga ng Kalihim ng Estado.

7. Pinipiling Partido. Kung ikaw ay nakarehistro sa isang partidong pulitikal na kwalipikado para sa pagkikilala ng balota, ikaw ay papahintulutan na bumoto para sa halalang primarya para sa partidong iyon. Kung ikaw ay nakarehistro bilang isang independyente, walang piniling partido o bilang isang miyembro ng isang partido na hindi kuwalipikado para sa pagkikilala ng balota, maaari kang pumili at bumoto ng isang balota para sa halalang primarya para sa isa sa mga nakilalang partidong pulitikal.

8. Grupo ng Lahi o Grupong Etniko. Iwanang blangko.

9. Lagda. Upang magparehistro sa Arizona, kailangan na ikaw ay:

- maging isang mamamayan ng Estados Unidos
- maging isang mamamayan ng Arizona at ng iyong county na kahit man lamang 29 araw bago ang sumunod na halalan.
- maging 18 taong gulang sa pagsapit o bago ang sumunod na pangkalahatang halalan
- hindi nasenyensyahan para sa pagtataksil sa bayan o isang paglalabag sa batas (o naipanumbalik ang iyong mga karapatang pantao)
- hindi kasalukuyang nadeklara bilang isang taong walang kakayahan ayon sa korte ng batas

Address Pang-Koreo:
Secretary of State/Elections
1700 W. Washington, 7th Floor
Phoenix, AZ 85007-2888

Arkansas

Pinabago: 03-01-2006

Huling araw na Inaasahan ang Rehistrasyon — 30 araw bago sumapit ang halalan.

6. Numero ng ID. Ang iyong nakumpletong form ng rehistrasyon ng botante ay dapat na naglalaman ng iyong numero ng lisensya sa pangmaneho na ipinalabas ng estado o hindi ipinapangasiwa na numero ng pagkakakilanlan. Kung wala kang lisensya sa pagmamaneho o hindi ipinapangasiwa na pagkakakilanlan, kailangan mong isama ang huling apat na mga numero ng iyong numero sa social security. Kung ikaw ay walang lisensya sa pangmaneho o hindi ipinapangasiwa na pagkakakilanlan o numero sa social security, mangyari lamang na isulat ang "WALA" sa form. Isang bukod-tanging numero ang itatalaga ng Estado.

7. Pagpili ng Partido. Hindi mo kailangang magparehistro sa isang partido kung nais mong maging bahagi sa halalang primarya, pagpupulong, o kombensiyon ng partido.

8. Grupo ng Lahi o Grupong Etniko. Iwanang blangko.

9. Lagda. Upang magparehistro sa Arkansas, kailangan na ikaw ay:

- maging isang mamamayan ng Estados Unidos
- nakatira sa Arkansas sa address sa Kahon 2 ng aplikasyon
- may kahit man lamang 18 taong gulang bago sumapit ang sumunod na halalan
- hindi isang nasentensyahang lumabag sa batas (o ay ganap na pinakawalan mula sa iyong sentensya o napatawad)
- hindi umangkin sa karapatan na bumoto sa iba pang hurisdiksyon
- hindi dating nahusgahan bilang walang kakayahang pangkaisipan ng isang korte na may legal na hurisdiksyon

Address Pang-Koreo:
Secretary of State
Voter Services
P.O. Box 8111
Little Rock, AR 72203-8111

California

Pinabago: 03-01-2006

Huling araw na Inaasahan ang Rehistrasyon — 15 araw bago sumapit ang halalan.

6. Numero ng ID. Kapag ikaw ay nagparehistro upang makaboto, kailangan mong ipagkaloob ang iyong lisensya sa pagmaneho sa California o card ng pagkakakilanlan sa California na numero, kung mayroon ka nito. Kung wala kang lisensya sa pagmamaneho o ID card, kailangan mong ipagkaloob ang huling apat na mga numero ng iyong numero sa social security o Social Security Number (SSN). Kung hindi mo isama ang impormasyon na ito, kailangan hilingin mula sa iyo na magbigay ng pagkakakilanlan kapag ikaw ay bumoto.

7. Pinipiling Partido. Mangyari lamang na ipasok ang pangalan ng partidong pulitikal kung saan nais mong magparehistro. Kung hindi mo nais na magparehistro sa kahit na anong partido, ipasok ang "Tumangging Ipahayag" sa espasyo na ipinagkaloob.

Pinapahintulutan sa ilalim ng batas ng California ang mga botante na "tumangging ipahayag" ang isang kinaaaniban na hindi kuwalipikadong partidong pulitikal na bumoto sa halalang primarya ng kahit na anong kuwalipikadong partidong pulitikal na nagsampa ng paunawa sa Kalihim ng Estado na nagpapahintulot sa kanila na gawin ito. Maaari kang tumawag sa 1-800-345-VOTE o bumisita sa www.ss.ca.gov upang matutunan kung aling mga partidong pulitikal ang nagpapahintulot na mga walang kinaaaniban na botante upang sumali sa kanilang primaryang halalan.

8. Grupo ng Lahi o Grupong Etniko. Iwanang blangko.

9. Lagda. Upang magparehistro sa California, kailangan na ikaw ay:

- maging isang mamamayan ng Estados Unidos
- maging isang mamamayan ng California
- may kahit man lamang 18 taong gulang sa pagsapit ng sumunod na halalan

• hindi makulong o malagay sa parole para sa pagkakasentensya para sa isang paglabag sa batas

• hindi kasalukuyang nahuhusgahan bilang walang kakayahang pangkaisipan ng isang korte ng batas

Kinakailangan ang lagda. Kung natugunan mo ang mga kahilingan na natala sa itaas, mangyari lamang na lagdaan at lagyan ng petsa ang kard ng rehistrasyon sa patlang na inilaan.

Address Pang-Koreo:
Secretary of State
Elections Division
1500 11th Street
Sacramento, CA 95814

Colorado

Pinabago: 03-28-2008

Huling araw na Inaasahan ang Rehistrasyon — 29 araw bago sumapit ang halalan. Kung ang aplikasyon ay natanggap sa koreo ng walang marka ng koreo, kailangan itong matanggap sa loob ng 5 araw ng pagsasara ng rehisktrasyon.

6. Numero ng ID. Ang iyong nakumpletong form ng rehistrasyon ng botante ay dapat na naglalaman ng iyong numero ng lisensya sa pangmaneho na ipinalabas ng estado o numero ng pagkakakilanlan. Kung wala kang lisensya sa pagmamaneho o pagkakakilanlan na ipinalabas ng estado, kailangan mong isama ang huling apat na mga numero ng iyong numero sa social security. Kung ikaw ay walang lisensya sa pangmaneho o pagkakakilanlan na ipinalabas ng estado o numero sa social security, mangyari lamang na isulat ang "WALA" sa form. Isang bukod-tanging numero ang itatalaga ng Estado.

7. Pinipiling Partido. Kailangan mong magparehistro sa isang partido kung nais mong maging bahagi sa halalang primarya, pagpupulong, o kombensiyon ng partido.

8. Grupo ng Lahi o Grupong Etniko. Iwanang blangko.

9. Lagda. Upang magparehistro sa Colorado, kailangan na ikaw ay:

• maging isang mamamayan ng Estados Unidos

• maging isang naninirahan sa Colorado ng 30 araw bago ang halalan

• may edad na 18 taong gulang sa pagsapit o bago ang araw ng halalan

• hindi namalagi bilang isang bilanggo o nagsisilbi ng kahit na anong bahagi ng sentensya sa ilalim ng isang kautusan.

Address Pang-Koreo:
Colorado Secretary of State
1700 Broadway, Suite 270
Denver, Colorado 80290

Connecticut

Pinabago: 03-01-2006

Huling araw na Inaasahan ang Rehistrasyon — 14 araw bago sumapit ang halalan.

6. Numero ng ID. Ang Numero ng Lisensya sa pagmamaneho sa Connecticut, o kung wala, ang huling apat na numero ng iyong Numero ng Social Security,

7. Pinipiling Partido. Ito ay opsyonal, pero kailangan mong magparehistro sa isang partido kung nais mong maging bahagi sa halalang primarya, pagpupulong, o kombensiyon ng partido.

8. Grupo ng Lahi o Grupong Etniko. Iwanang blangko.

9. Lagda. Upang magparehistro sa Connecticut, kailangan na ikaw ay:

• maging isang mamamayan ng Estados Unidos

• maging isang naninirahan sa Connecticut at ng bayan kung saan mo nais bumoto

• may edad na 17 taong gulang. Maaari kang bumoto kapag ikaw ay sumapit sa edad na 18.

• nakapagkumpleto sa pagkakakulong at parole kung dating nasentensyahan sa isang paglalabag sa batas, at naipanumbalik ang iyong mga karapatan sa pagboto ng Tagapagrehistro ng Mga Botante.

• hindi kasalukuyang napahayag bilang walang kakayahan na bumoto ng isang korte ng batas

Address Pang-Koreo:
Secretary of State
Elections Division
30 Trinity Street
Hartford, CT 06106

Delaware

Pinabago: 02-07-2012

Huling araw na Inaasahan ang Rehistrasyon — Ang ika-4 na Sabado bago sumapit ang primarya o pangkalahatang halalan, at 10 araw bago ang isang espesyal na halalan.

6. Numero ng ID. Ang iyong nakumpletong form ng rehistrasyon ng botante ay dapat na naglalaman ng iyong numero ng lisensya sa pangmaneho na ipinalabas ng estado o hindi ipinapangasiwa na numero ng pagkakakilanlan. Kung wala kang lisensya sa pagmamaneho o hindi ipinapangasiwa na pagkakakilanlan, kailangan mong isama ang huling apat na mga numero ng iyong numero sa social security. Kung ikaw ay walang lisensya sa pangmaneho o hindi ipinapangasiwa na pagkakakilanlan o numero sa social security, mangyari lamang na isulat ang "WALA" sa form. Isang bukod-tanging numero ang itatalaga ng Estado.

7. Pinipiling Partido. Kailangan mong magparehistro sa isang partido kung nais mong maging bahagi sa halalang primarya, pagpupulong, o kombensiyon ng partido.

8. Grupo ng Lahi o Grupong Etniko. Iwanang blangko.

9. Lagda. Upang magparehistro sa Delaware, kailangan na ikaw ay:

• maging isang mamamayan ng Estados Unidos

• maging isang permanenteng residente ng Delaware