DESCHUTES COUNTY HEALTH SERVICES

INTENSIVE YOUTH SERVICES BEHAVIORAL HEALTH SCREENING REQUEST

Email to: intensiveyouthservices@deschutes.org Fax: 541-617-4793 Phone: 541-213-6851

CHILD/YOUTH/YOUNG ADULT: _____ DOB: _____/_____/_____

PREFERRED GENDER/PRONOUN:_____ INDIVIDUAL'S PRIMARY LANGUAGE_____

PARENT'S PRIMARY LANGUAGE _____ PARENT/GUARDIAN NAME:_____

ADDRESS _____CITY _____

HOME PHONE _____ ALT. PHONE _____

REASON FOR REQUEST:

Reason for Referral (attach supporting data): _____

Requested Screening for:

- ☐ Early Assessment and Support Alliance 15-27 years of age
- ☐ Young Adults in Transition 14-25 years of age
- ☐ ICTS Wrap Around 0-18 years of age
- ☐ Day Treatment 5-12 years of age
- ☐ Unsure

Other Services Youth is currently Receiving:

- ☐ Individual Education Plan / 504
- ☐ Primary Care Provider: _____
- ☐ Medications (Provided by):_____
- ☐ Individual Counseling:_____

Multiple System Involvement:

- ☐ DHS (Department of Human Services; Child Welfare)
- ☐ Juvenile Community Justice / Oregon Youth Authority
- ☐ Intellectual Development Disabilities
- ☐ Substance Abuse Treatment

Insurance Type:

- ☐ Oregon Health Plan
- ☐ DMAP Fee For Service Oregon Health Plan
- ☐ Private Insurance (MODA, Pacific Source, Regence, AETNA, Health Net, PBHI Pro, Health Net)
- ☐ No Insurance

PERSON AND/OR AGENCY REQUESTING SCREENING: _____

Phone Number:_____ Mailing Address:_____

SIGNATURE _____ _____DATE _____

(Person and/or agency requesting the screening is not responsible for the approval or denial of the referral, the outcome of the referral or any financial obligation.

CONSENT FOR SCREENING

No screening, evaluation, or assessment will be conducted without parent / client consent. Screening does not guarantee admission into services.

Parent/ Guardian Complete for children 0 to 13 years of age/Client completes if age 14 years or older

Please Complete This Part:

- o I give my consent to conduct the above checked mental health screening.
- o I do not give my consent to conduct the above checked screening.

Parent/Guardian SIGNATURE _____ DATE_____

Client SIGNATURE _____ DATE_____

Authorization to exchange information (attached)

Optional (for screening consideration only):

Early Assessment and Support Alliance Criteria
Must meet all of the following:

___ 1. Resides in Deschutes, Jefferson or Crook Counties
___ 2. Age 15-27
___ 3. The person has an IQ of 70 or above and does not have a previous diagnosis of a pervasive developmental disorder (e.g. Autism, Asperger's).
___ 4. The person has not received treatment for a psychotic illness prior to the last 12 months.
___ 5. Psychotic symptoms are not known to be caused by the temporary or chronic effects of substance abuse or a known medical condition.
___ 6. The person has experienced a significant decline in either academic, vocational, social or personal (sleep, hygiene) functioning.

And must meet *either* 7 *or* 8 below:

___ 7. The individual has experienced significant worsening or new symptoms in one or more of the following areas *in the last 12 months:*

a. Thought disorganization as evidenced by disorganized speech and or/ writing. (Examples: confused conversations, not making sense, never getting to a point, unintelligible).
b. Behaviors, speech or beliefs are uncharacteristic and/or bizarre.
c. Complains of hearing voices or sounds that others do not hear.
d. The individual feels that other people are putting thoughts in their head, stealing their thoughts, believes others can read their mind (or vice versa), and/or hear their own thoughts out loud.
e. Episodes of depersonalization (Example: They believe that they do not exist or that their surroundings are not real).
f. Heightened sensitivities (lights, sounds etc.) and/or is experiencing visual distortions
g. Increased fear, anxiety or paranoia for no apparent reason or for an unfounded reason.

OR

___ 8. Family history of a 1st degree relative (sibling or parent) with a major psychotic disorder

Young Adults in Transition Criteria

___1. Individual has Oregon Health Plan insurance, does not have any form of insurance or has recently been hospitalized and exhausted private insurance resources.
___2. Individual is seeking mental health support as the primary reason for seeking services.
___3. Residency - The parents, guardian or primary care giver of eligible children and youth will live in Deschutes County.
___4. Age - Eligible youth will be from 14 through 25 years of age. Youth in need of mental health treatment- Eligible youth will be determined to have need of mental health treatment.
___5. Under supported youth: Youth that are involved with Juvenile Community Justice, Oregon Youth Authority, Department of Human Services, homeless youth and youth will minimal natural supports.
___6. Transition: Youth transitioning out of Wraparound or EASA programs. Youth who do not meet criteria for EASA

Intensive Children's Treatment Services ICTS (Wraparound) Criteria

___1. Individual has Oregon Health Plan insurance, does not have any form of insurance or has recently been hospitalized and exhausted private insurance resources.
___2. Individual is seeking mental health support as the primary reason for seeking services.
___3. Risk for out of home placement (higher level of care, child welfare or juvenile justice Involvement).
___4. Involvement in multiple agencies (special education, juvenile justice, developmental disabilities services, child welfare etc.)
___5. A mental health disorder not likely to resolve in 6 months or less
___6. Previous mental health treatment has been unsuccessful.
___7. Recent serious mental health episode (suicide attempt or ideation, rapid deterioration of functioning, recent hospitalization, homicidal ideation or actions).
___8 .Families with multiple barriers to engagement and treatment and limited resources
___9. Child and Adolescent Service Intensity Instrument Score of 3- 6,- highest levels of care or for children under the age of 5 an Early Childhood Service Intensity Instrument Sore of 4-5, - highest levels of care.

Disposition (Completed by Screener):

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