2/96

ESSEX COUNTY MENTAL HEALTH SERVICES

CHILD & ADOLESCENT HEALTH ASSESSMENT

TO BE COMPLETED BY AN ADULT WHO KNOWS THE CHILD'S HEALTH HISTORY

COMPLETED BY:_____ DATE:_____

CHILD'S NAME:_____ DOB:_____ SEX: M_____ F_____

FAMILY DOCTOR OR PEDIATRICIAN:_____

OTHER DOCTOR(S) TREATING CHILD:_____

CHILD'S LAST PHYSICAL (MONTH/YEAR):_____

HAS CHILD HAD VISION & HEARING CHECKED? YES____ NO____ (If yes, date:_____)

CHILD'S LAST VISIT TO A DOCTOR (MONTH/YEAR):_____

CHILD'S LAST VISIT TO A DENTIST (MONTH/YEAR):_____

IF CHILD HAS ANY HEALTH PROBLEMS, PLEASE LIST THEM:_____

_____

IF CHILD IS TAKING ANY MEDICATION(S), PLEASE LIST THEM:_____

_____

IF CHILD HAS ANY ALLERGIES, PLEASE LIST THEM:_____

_____

IF CHILD HAS EVER BEEN HOSPITALIZED OR RECEIVED EMERGENCY ROOM CARE, PLEASE DESCRIBE:

_____

ARE THERE ANY OTHER HEALTH CONCERNS? PLEASE DESCRIBE:_____

_____

HAS CHILD EVER:

- HAD A HEAD INJURY? YES_____ NO_____
- HAD A HIGH FEVER FOR MORE THAN 2 DAYS? YES_____ NO_____
- FAINTED OR LOST CONCIOUSNESS? YES_____ NO_____
- BEEN ABSENT FROM SCHOOL DUE TO ILLNESS FOR A WEEK OR MORE? YES_____ NO_____
- USED ALCOHOL? YES___ NO___ DRUGS? YES___ NO___ CIGARETTES? YES___ NO___

DOES CHILD HAVE:

- DAY & NIGHT BLADDER CONTROL? YES_____ NO_____ BOWEL CONTROL YES_____ NO_____
- ANY "NERVOUS" HABITS THAT YOU ARE CONCERNED ABOUT? YES_____ NO_____ IF YES, PLEASE DESCRIBE:_____

_____

_____

(Please continue on next page)

ARE YOU CONCERNED ABOUT CHILD'S:

EATING HABITS? YES ______ NO_____ SLEEPING HABITS? YES______ NO_____

HAS YOUR DAUGHTER STARTED HER PERIOD? YES ___ NO___ IF YES, DATE STARTED________________

IS YOUR CHILD BEING TREATED FOR A MEDICAL PROBLEM NOW? YES____ NO____ IF YES, PLEASE DESCRIBE____

WERE THERE ANY PROBLEMS WITH YOUR CHILD'S PREGNANCY? YES_____ NO_____ IF YES, PLEASE DESRIBE:____

ARE THERE ANY SERIOUS HEALTH PROBLEMS THAT RUN IN YOUR FAMILY YES_____ NO_____ IF YES, PLEASE DESCRIBE (e.g. heart disease, liver problems, kidney disease, diabetes, etc.):______________

TO THE BEST OF YOUR KNOWLEDGE. HAS YOUR CHILD EVER BEEN PHYSICALLY OR SEXUALLY MISTREATED? YES_____ NO_____ IF YES, PLEASE DESCRIBE:______________________

HAVE YOU EVER BEEN CONCERNED ABOUT YOUR CHILD'S GROWTH OR DEVEOPMENT?:YES___ NO___

IF YES, PLEASE DESCRIBE:____

IS YOUR CHILD HAVING SCHOOL PROBLEMS? YES_____ NO_____ IF YES, PLEASE DESCRIBE__________

FOR OFFICE USE ONLY

RECOMMENDATIONS:____

STAFF SIGNATURE:____

M.D. SIGNATURE:____

Acknowledgement of Receipt of Notice of Privacy Practices and Patient's Bill of Rights

This form is being provided to acknowledge your receipt of our Notice of Privacy Practices and the Patient's Bill of Rights.

What is the Notice of Privacy Practices?

The Notice of Privacy Practices explains how your patient health information may be used or disclosed by us. In addition, it explains your rights with regard to your patient health information as well as our legal responsibilities.

What is the Patient's Bill of Rights?

The Patient's Bill of Rights describes the rights you have as a patient at this clinic.

Acknowledgement of Receipt

By signing below, you are acknowledging that the Notice of Privacy Practices and the Patient's Bill of Rights have been provided to you:

I, _____
Patient's Name (please print)

residing at:

_____
Patient's Address

have received the Notice of Privacy Practices and the Patient's Bill of Rights from Essex County Department of Mental Health.

_____ _____
Signature Date

(Note: This document should be retained for six years from the date of its creation or the date when it was last in effect, whichever is later.)

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

ESSEX COUNTY DEPARTMENT OF MENTAL HEALTH HAS A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI). All employees, volunteers, staff, doctors, health professionals and other personnel are legally required to and must abide by the policies set forth in this notice to protect the privacy of your health information.

This "protected health information", or PHI for short, includes information that can be used to identify you. We collect or receive this information about your past, present or future health condition to provide health care to you, or to receive payment for this health care. We must provide you with this notice about our privacy practices that explain how, when and why we use and disclose (release) your PHI. With some exceptions, we may not use or release any more of our PHI than is necessary to accomplish the need for the information. We must abide by the terms of the notice of privacy practices currently in effect.

We reserve the right to change the terms of this notice and our privacy policies at any time. Any changes to this notice willapply to the PHI already in existence. Before we make any change to our policies, we will promptly change this notice and post a new notice in our lobby. You can also request a copy of this notice from the contact person listed at the end this notice at anytime and can view a copy of the notice on our web site at www.co.essex.ny.us .

WE MAY USE AND RELEASE YOUR PROTECTED HEALTH INFORMATION for many different reasons. For some of these reasons, we will need your permission or a specific, signed authorization. Below, we describe the different categories of when we use and release your PHI, give you some examples of each category and tell you when we need your permission.

A. WE MAY USE, OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. YOUR CONSENT IS NOT REQUIRED FOR THESE PURPOSES.

1. For Treatment. We may release your PHI to physicians, nurses, medical students, and other health care personnel and agencies and business associates who provide or are involved in your health care. For example, if you are being treated for mental condition, we may release your PHI to other county departments/programs in order to coordinate your care.

2. To obtain payment for treatment. We may use and release your PHI in order to bill and collect payment for services provided to you. It is important that you provide us with correct and up-to-date PHI. For example, we may release portions of your PHI with our billing department and your health plan to get paid for the health care services we provided to you. We may also release your PHI to our business associates, such as billing companies, claims processing companies and others.

3. To run our health care business. We may release your PHI in order to operate our facility in compliance with healthcare regulations. For example, we may use your PHI to review the quality of our services and to evaluate the performance of our staff in caring for you.

4. To New York State and Other Departments of Essex County. We communicate information required to be given to New York State. We also communicate information with other departments/programs of Essex County to give you the best treatment plan possible, as well as for our payment and business operations purposes.

B. WE ALSO DO NOT REQUIRE YOUR CONSENT TO USE OR RELEASE YOUR PHI:

1. When federal, state, or local law; judicial or administrative proceedings; or law enforcement agencies request your Protected Health Information. We release your Protected Health Information only when a law requires that we report information to government agencies or law enforcement personnel. Specifically we would notify the New York State Child Abuse Registry about victims of child abuse, or neglect. We would also notify Law Enforcement officials about the following: for notification and identification purposes when a crime has occurred; in missing person cases; or when ordered in a judicial or administrative proceeding.

2. For public health activities. We report information about births, deaths, and various diseases to government officials in charge of collecting that information and we provide coroners, medical examiners and funeral directors necessary information relating to an individual's death.

3. To avoid harm. In order to avoid a serious threat to health or safety of a person or the public, we may provide your demographic PHI to law enforcement personnel or persons able to prevent or lessen such harm.

4. For worker's compensation purposes. We may release your PHI in order to comply with worker's compensation laws. If you do not want worker's compensation notified, alternate insurance or payment information must be supplied.

6. For appointment reminders and health-related benefits and services. We may use your demographic PHI to contact you as a reminder that you have an appointment or to recommend possible treatment options or alternatives that may be of interest to you.

7. For health oversight activities. We may use PHI and may disclose PHI to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for oversight of the health care system, government benefit programs, or entities subject to government regulation or civil rights laws.

C. YOU HAVE THE OPPORTUNITY TO AGREE TO OR OBJECT TO THE FOLLOWING:

1. Information shared with family, friends or others. We may release your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. Your choice to object may be made at any time. You will be notified if one of the persons asks to access your PHI.

D. YOUR PRIOR WRITTEN AUTHORIZATION IS REQUIRED FOR ANY USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION NOT INCLUDED ABOVE. We will ask for your written authorization before using or releasing any of your PHI except as previously stated, or in an emergency situation. If you choose to sign an authorization to release your PHI, you may later cancel that authorization in writing. This will stop any future release of your PHI for the purposes you previously authorized.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

A. You Have the Right to Request Limits on How We Use and Release Your PHI. If we accept your request, will put any limits in writing and abide by them except in emergency situations. You may not limit PHI that we are legally required or allowed to release.

B. You Have the Right to Choose How We Communicate PHI to You. All of our communications to you are considered confidential. You have the right to ask that we send information to you to an alternative address (for example, sending information to your work address rather than your home address) or by alternative means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested. Any additional expenses will be passed onto you for payment.

An example of this is our "message phones". These are phone numbers that you may provide to us so we can leave a message for your to call us if you currently do not have your own phone. Should you provide us with a phone number at which we can leave a message for you to call us, you may withdraw permission for use of such "message phone" at any time.

C. You Have the Right to See and Get Copies of Your PHI. You must make the request in writing. We will respond to you within 5* days after receiving your written request. In certain situations, we may deny your request. If we do, we will tell you, in writing, why we denied your request. You have the right to have the denial reviewed if you make a request in writing within 30* business days. We will choose another licensed healthcare professional to review your request and the denial. The person conducting the review will not be the person who denied your first request and must make a decision within 7* business days. You can request a summary or a copy of the entire medical record as long as you agree to the cost in advance. If your request to see the medical information is approved, we will arrange this in accordance with established hospital policy. Please submit all requests for this information to: Assistant Director of Mental Health

D. You Have the Right to Get a List of Instances of When and to Whom We Have Disclosed Your PHI.

This list **will not** include uses you have already authorized, or those for treatment payment or operations. This list **will not** include uses made for national security purposes, to corrections or law enforcement personnel, if you were in custody, or disclosures made before April 14, 2003. We will respond within 60 days of receiving your request. The list we provide will include the last six years of activity unless you request a shorter time. The list will include dates when your PHI was released and why, with whom your PHI was released (including their address if known), and a description of the information released. The first list you request within a 12-month period will be free. You will be charged a reasonable fee for additional lists within that time frame. Please submit all requests for this information to:

Assistant Director of Mental Health.

E. You have the Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing or add the missing information. We can do this for as long as the information is retained by our facility. You must provide the request and your reason for the request in writing. We will respond within 30* days of receiving your request. If we deny your request, our written denial will state our reasons and explain your right to file a written appeal* within 7* business days. If you choose to appeal, you appeal must be processed within 30* business days. You may also choose to submit a written statement of disagreement. If you do not file a written statement of disagreement, you have the right to request that your request and our denial be attached to all future uses or releases of your PHI. If we approve your request, we will make the change to your PHI, tell you that we have done it, and tell others that need to know about the change or amendment to your PHI. Please submit all requests for this information to:

Assistant Director of Mental Health.

F. You have the Right to Get This Privacy Notice by email. Even if you have agreed to receive notice via email, you also have the right to request a paper copy of this notice. Please submit this request to: Assistant Director of Mental Health

HOW TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES: If you think that we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed below or with the Secretary of the DHHS:

PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO VOICE YOUR CONCERNS ABOUT OUR PRIVACY PRACTICES:

Essex County Privacy Officer
(518) 873-3380
You will not be penalized for filing a complaint.

EFFECTIVE DATE OF THIS NOTICE
This notice went into effect on April 14, 2003.

*Are New York State law requirements

Essex County

Community Services Board
Geoffrey Neu, Chairperson
Stephen J. Valley, LCSW
Director

P.O. Box 8 – 7513 Court Street
Elizabethtown, NY 12932
(518) 873-3670
Fax (518) 873-3777

Mental Health Services
Stephen J. Valley, LCSW
Director
Annie G. McKinley, LCSW
Assistant Director

Attendance Policy Fact Sheet

You and your therapist are working together so you can reach your treatment goals. During the first 2-3 appointments your therapist, with your help, is assessing your strengths and needs. Your treatment plan is based on this assessment. Together you identify goals to work on in treatment and how often and how long your appointments should be. Attendance is necessary for progress in treatment. When you sign the Statement of Understanding and your Treatment Plan you are agreeing to come to all scheduled appointments or cancelling more than 24 hours before your appointment so someone else in need of the service can be scheduled in the slot that you had.

When you miss more than 50% of your scheduled appointments in a three month period you will be put on "standby " status. This means that you cannot schedule appointments but you can be seen on a walk-in basis. You can call in the morning to see if your therapist or prescriber has an open hour but the time will not be reserved for you. You must come in prepared to wait and hope that you can be seen. All standby appointments will be at the Elizabethtown clinic only. You will be suspended from participation in group therapy while on standby. You will not receive prescriptions while on standby status without seeing your prescriber.

While you are on standby status you must be seen once within 30 days of being told of standby status or you will be discharged. In order to get off standby status you must be seen as a walk-in 3 times within 60 days of being told of standby status. Your therapist and the front office staff will do their best to help you solve any attendance/transportation problems so you can attend regularly and reach your goals.

THIRD PARTY PRIVATE INSURANCE CARRIERS

Essex County Mental Health (ECMH) may not be a participating provider with your health insurance company. ECMH will still submit claims to your insurance company for the services we provide. In this case, your insurance company may send checks directly to you. We will not expect payment from you until your insurance company sends the check, with the understanding that you:

1. Pay your co-pay every time you come to the clinic and receive services.

2. Bring all insurance checks and statements to the clinic as soon as you get them.
    a. ECMH is willing to accept the insurance payment plus your co-pay as payment in full for our services.
    b. If there is <u>one</u> incident in which you do not bring an insurance check to ECMH for payment for services we provided to you, we will require you to make full payment (insurance amount plus co-pay) each time before receiving services.

Please be aware that failure to do either 1 or 2 above could be considered insurance fraud.

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Annie McKinley, LCSW-R
Assistant Director

Essex County Mental Health Fee Policy – client handout

Our fee policy is intended to help keep you from building a past due balance which is unmanageable and can become a barrier to successful treatment.

- A self-pay fee is set when you register for services. This is based on a sliding scale depending on your income.

- If you have health insurance, your plan may have a co-pay. We are required by law to collect the full co-pay fee, even if your self-pay fee is lower.

- Your self-pay fee or co pay fee is expected to be paid in full every time you come for services. We accept payment by cash, check or credit/debit card.

- If you feel that you cannot afford your self-pay fee or co-pay fee, you can request a fee adjustment. Please tell the receptionist or your therapist right away so that we can help you start the process quickly. This will help you to avoid building a past due balance.

- As of June 1, 2015, if you owe us for 2 sessions or more, we will not schedule any new appointments until you: (1) pay your balance down to one session or less, OR (2) complete a Payment Plan Agreement (PPA).

- If you have a past due balance from prior treatment, you will be expected to pay the balance in full OR submit a PPA, before being seen by a therapist for your registration appointment. Our staff will help you to complete the PPA.

- If you agree to a PPA, you must pay the amount in your PPA plus your self-pay or co-pay fee before each appointment, or you will not be seen that day.

Essex County

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Director
Annie McKinley, LCSW-R
Assistant Director

PATIENT'S BILL OF RIGHTS

An individual admitted to this clinic is entitled to the following rights:

1. An individual plan of treatment in which you have participated.
2. An explanation of the services provided in that treatment plan.
3. Voluntary participation in treatment, unless you are court ordered here, or you present a risk of physical harm to yourself or others.
4. To object to or disagree with any portion of your treatment plan.
5. To have all your records protected by confidentiality.
6. To have access to your records, unless there is a clinical reason why you should not.
7. To receive clinically appropriate care and to be treated humanely and with dignity.
8. To receive services free of discrimination.
9. To be treated in a way which acknowledges and respects your cultural environment
10. To receive the maximum amount of privacy consistent with the effective delivery of service.
11. To be free from abuse and mistreatment by employees of this clinic.
12. To be informed of the clinic's Grievance Policy.

The addresses and phone numbers below are for those organizations who have an interest in ensuring proper operation of this clinic or in the rights of mentally ill individuals in New York State.

New York State
Commission on Quality of Care
Suite 1002, 99 Washington Ave
Albany, NY 12210
(518)473-4090
1-800-624-4131

New York State
Alliance for the Mentally III (AMI)
260 Washington Avenue
Albany, NY 12210
(518)462-2000

NYS Office of Mental Health
Central New York Field Office
545 Cedar Street
Syracuse, NY 13201
(315) 472-2093
Customer Relations:
1-800-597-8481

National Alliance for Mental Illness
for Champlain Valley
14 Healey Avenue
Plattsburgh, NY 12901
(518) 561-2685

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STATEMENT OF UNDERSTANDING WITH ESSEX COUNTY MENTAL HEALTH SERVICES

We are glad you have chosen to seek mental health services at our clinic. To obtain as much as you can out your time here with us, there are a few things that need to be pointed out, such as what you can expect from us, and expectations we have of you. As these are presented briefly, please be sure to talk to your therapist in detail about any of these issues of concern to you.

TREATMENT TEAM We work with a treatment team approach. You will have a therapist assigned to you. You and your therapist will develop a treatment plan which lists your goals and objectives of treatment, what you want to accomplish, and will work on, during your time here. If you will need psychotropic medications, you may also see our psychiatrist or nurse practitioner for your medication needs. The psychotropic prescriber and therapist work together and discuss your care from time to time. Your care is also discussed periodically during a treatment team review.

COORDINATION OF CARE If you are receiving services from other providers such as a school, DSS, Families First, MHA, or a case manager, your therapist will need to contact these agencies to coordinate care in your best interest. If your primary care provider prescribes psychotropic medications for you, or is treating you for medical concerns, your therapist will need to contact him or her periodically as well. Any outside agency contact will require a release of information signed by you (or your parent/guardian, if a minor).

CONFIDENTIALITY is maintained to the standards outlined by the New York State Office of Mental Health as well as New York State and Federal Law. What you say in session is held confidential within the clinic. There are exceptions to confidentiality, such as in the reporting of child abuse, expression of suicidal/homicidal plan or intent, or a court order. Also, your insurance company or Medicaid has the right to access your records. Anyone to whom you authorize release of information, also has right of access to information. Please talk with your therapist for more details, and about your concerns of confidentiality.

KEEPING APPOINTMENTS The professionals in this clinic are committed to quality care and to working with you in achieving optimal mental health. They will make appointments with you with the expectation that you keep these appointments. Your frequency of sessions is based on your particular needs. If you cannot keep an appointment, please call at least 24 hours in advance so that we can schedule someone else in your place. If you miss any of your first three appointments, we may cancel your referral. Once you are an admitted client here, if you do not attend or cancel several of your appointments, your therapist will address this with you. If you miss more than half of your appointments in any three month period, you will be placed on standby status. This means that you will not be able to schedule appointments, but you will be able to be seen on a walk in basis. Please refer to the attendance policy in your referral packet for more specifics on "standby" status procedure. **Please be aware that our policy does call for immediate cancellation of your referral if you were just assigned to a therapist and you did not show for your first appointment.**

COMPLAINTS If you have a complaint as to your care, please try to discuss this with your therapist or psychiatrist first. If it is not resolved, please call the Assistant Director of the clinic. You may also request a copy of our grievance procedure, and a copy of the Outpatient Patient Bill of Rights, at any time.

PAYMENT is expected at the time of service.

(If reviewed in session)This has been reviewed with me. I understand and agree to the statement contained therein.

Client (parent/guardian) Signature _____Date Reviewed _____

Therapist Signature _____

Parent To Fill Out On Themself

ESSEX COUNTY MENTAL HEALTH SERVICES

Modified Simple Screening Instrument for Substance Abuse (MSSI-SA)
Self-Administered Form

Name _____ Date _____

Directions: The questions that follow are about your use of alcohol and other drugs, including prescription and over-the-counter medication/drugs. Your answers will be kept private. Mark the response that best fits for you.

Filling out this form assists us in identifying your needs and providing you with services. Your answers on this form will not exclude you from services, care or treatment at this program.

Answer questions 1-13 in terms of your experiences in the past 6 months:

	Yes	No
1a. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants) 1b. Have you used prescription or over-the-counter medication/drugs? (Such as sleeping pills, pain killers, sedatives, or anti-anxiety medication like Valium, Xanax, or Ativan)		
2. Have you felt that you use too much alcohol or other drugs? (Other drugs also include prescription or over-the-counter medication more than recommended.)		
3. Have you tried to cut down or quit drinking or using alcohol or other drugs?		
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.)		

5. Have you had any health problems? Please check if you have:
   - ___ Had blackouts or other periods of memory loss?
   - ___ Injured your head after drinking or using drugs?
   - ___ Had convulsions, delirium tremens ("DTs")?
   - ___ Had hepatitis or other liver problems?
   - ___ Felt sick, shaky, or depressed when you stopped?
   - ___ Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?
   - ___ Been injured after drinking or using?
   - ___ Used needles to shoot drugs?

Please continue □

Child's Name _____ Age _____ Sex (Circle): Girl Boy
Person Completing this Form _____ Relationship to Child _____
Today's Date (**write month, day and year**) _____ Grade in School _____
School _____ Teacher _____ Town _____

Below is a list of VERY SCARY, DANGEROUS, OR VIOLENT things that sometimes happen to children. These are times where someone was HURT VERY BADLY OR KILLED, or could have been. Some children have had these experiences, some children have not had these experiences.

FOR EACH QUESTION: Check "Yes" if this scary thing **HAPPENED TO YOUR CHILD**
Check "No" if it **DID *NOT* HAPPEN TO YOUR CHILD**

1) Being in a big earthquake that badly damaged the building your child was in. Yes [ ] No [ ]

2) Being in another kind of **disaster**, like a fire, tornado, flood or hurricane. Yes [ ] No [ ]

3) Being in a bad **accident**, like a **very serious** car accident. Yes [ ] No [ ]

4) Being in place where a **war** was going on around your child. Yes [ ] No [ ]

5) Being **hit, punched, or kicked very hard** at home. (**DO NOT INCLUDE** ordinary fights between brothers & sisters). Yes [ ] No [ ]

6) Seeing a family member being **hit, punched or kicked very hard** at home. (**DO NOT INCLUDE** ordinary fights between brothers & sisters). Yes [ ] No [ ]

7) Being **beaten up, shot at or threatened to be hurt badly** in your town. Yes [ ] No [ ]

8) Seeing someone in your town being **beaten up, shot at or killed.** Yes [ ] No [ ]

9) Seeing a **dead body** in your town (do not include funerals). Yes [ ] No [ ]

10) Having an adult or someone much older touch your child's **private sexual body parts** when your child did not want them to. Yes [ ] No [ ]

11) Hearing about the **violent death or serious injury** of a loved one. Yes [ ] No [ ]

12) Having **painful and scary medical treatment in a hospital** when your child was very sick or badly injured. Yes [ ] No [ ]

13) **OTHER** than the situations described above, has **ANYTHING ELSE** ever happened to your child that was **REALLY SCARY, DANGEROUS, OR VIOLENT?** Yes [ ] No [ ]
Please write what happened: _____

Contact: UCLA Trauma Psychiatry Service/ 300 UCLA Medical Plaza, Ste 2232
Los Angeles, CA 90095 -6968
(310) 206-8973/ EMAIL: rpynoos@mednet.ucla.edu

14) a) If you answered "YES" to only **ONE** thing in the above list of questions #1 to #13, place the number of that thing (#1 to #13) in this blank. # _____

b) If you answered "YES" to **MORE THAN ONE THING,** place the number of the thing that **BOTHERS YOUR CHILD THE MOST NOW** in this blank. #_____

c) About how long ago did this bad thing (your answer to Aa≅ or Ab≅) happen to your child? _____

d) Please write what happened: _____

_____

FOR THE *NEXT* QUESTIONS, please **CHECK "Yes, No, or Don't know"** to answer **HOW YOUR CHILD FELT during or right after** the experience happened that you just wrote about in Question 14. Only check "Don't Know" if you absolutely cannot give an answer.

15) Was your child afraid that he/she would die?	Yes [ ]	No [ ]	Don't know [ ]
16) Was your child afraid that he/she would be seriously injured?	Yes [ ]	No [ ]	Don't know [ ]
17) Was your child seriously injured?	Yes [ ]	No [ ]	
18) Was your child afraid that someone else would die?	Yes [ ]	No [ ]	Don't know [ ]
19) Was your child afraid that someone else would be seriously injured?	Yes [ ]	No [ ]	Don't know [ ]
20) Was someone else seriously injured?	Yes [ ]	No [ ]	
21) Did someone die?	Yes [ ]	No [ ]	
22) Did your child feel terrified?	Yes [ ]	No [ ]	Don't know [ ]
23) Did your child feel intense helplessness?	Yes [ ]	No [ ]	Don't know [ ]
24) Did your child feel horrified; was what he/she saw disgusting or gross?	Yes [ ]	No [ ]	Don't know [ ]
25) Did your child get hysterical or run around?	Yes [ ]	No [ ]	Don't know [ ]
26) Did your child feel very confused?	Yes [ ]	No [ ]	Don't know [ ]
27) Did your child feel like what was happening did not seem real in some way, like it was going on in a movie instead of real life?	Yes [ ]	No [ ]	Don't know [ ]

Here is a list of problems children sometimes have after very stressful experiences. Please think about your child's stressful experience that you wrote about in Question #14. Then, read each problem on the list carefully. CIRCLE one of the numbers (0, 1, 2, 3, 4 or 5) that tells how often the problem has happened to your child **in the past month**. Refer to the **Rating Sheet** (on page 5) to help you decide how often the problem has happened. Note: If you are unsure about how often your child has experienced a particular problem, then try to make your best estimation. **Only** circle **"Don't Know"** if you absolutely **cannot** give an answer. **PLEASE BE SURE TO ANSWER ALL QUESTIONS**

	None	Little	Some	Much	Most	Don't Know
1[D4] My child watches out for danger or things that he/she is afraid of.	0	1	2	3	4	5
2[B4] When something reminds my child of what happened he/she gets very upset, scared or sad.	0	1	2	3	4	5
3[B1] My child has upsetting thoughts, pictures or sounds of what happened come into his/her mind when he/she does not want them to.	0	1	2	3	4	5
4[D2] My child feels grouchy, angry or mad.	0	1	2	3	4	5
5[B2] My child has dreams about what happened or other bad dreams	0	1	2	3	4	5
6[B3] My child has flashbacks of what happened; he/she feels like he/she is back at the time when the bad thing happened living through it again.	0	1	2	3	4	5
7[C4] My child feels like staying by him/her self and not being with his/her friends.	0	1	2	3	4	5
8[C5] My child feels alone inside and not close to other people.	0	1	2	3	4	5
9[C1] My child tries not to talk about, think about, or have feelings about what happened.	0	1	2	3	4	5
10[C6] My child has trouble feeling happiness or love.	0	1	2	3	4	5
11[C6] My child has trouble feeling sadness or anger.	0	1	2	3	4	5
12[D5] My child feels jumpy or startles easily, for example, when he/she hears a loud noise or when something surprises him/her.	0	1	2	3	4	5
13[D1] My child has trouble going to sleep or wakes up often during the night.	0	1	2	3	4	5
14[AF] My child feels that some part of what happened is his/her fault.	0	1	2	3	4	5

	None	Little	Some	Much	Most	Don't Know
15[C3] My child has trouble remembering important parts of what happened.	0	1	2	3	4	5
16[D3] My child has trouble concentrating or paying attention.	0	1	2	3	4	5
17[C2] My child tries to stay away from people, places, or things that make him/her remember what happened.	0	1	2	3	4	5
18[B5] When something reminds my child of what happened, he/she has strong feelings in his/her body like heart beating fast, head aches, or stomach aches.	0	1	2	3	4	5
19[C7] My child thinks that he/she will not live a long life.	0	1	2	3	4	5
20[AF] My child is afraid that the bad thing will happen again.	0	1	2	3	4	5
21[B1] My child plays games or draws pictures that are like some part of what happened.	0	1	2	3	4	5

Date: _____ Name/ID: _____

RCADS – D (Parent Version)

Instructions: **Please put a circle around the word that shows how often each of these things happen to you. There are no right or wrong answers.**

1. My child feels sad or empty . . . . . Never Sometimes Often Always

2. Nothing is much fun for my child anymore. . . Never Sometimes Often Always

3. My child has trouble sleeping . . . . . Never Sometimes Often Always

4. My child has problems with his/her appetite...Never Sometimes Often Always

5. My child has no energy for things . . . . . Never Sometimes Often Always

6. My child is tired a lot . . . . . Never Sometimes Often Always

7. My child cannot think clearly . . . . . Never Sometimes Often Always

8. My child feels worthless. . . . . Never Sometimes Often Always

9. My child feels like he/she doesn't want to move. . . . . Never Sometimes Often Always

10. My child feels restless . . . . . Never Sometimes Often Always

PARENT – ASSESSMENT
Revision Date 05/28/15

Individual's Name (First/M/Last):	Record#:
Date of Admission:	Date:

What are your goals for your child?
Is there anything that stops your child from pursuing these goals? ☐Yes ☐ No – If yes, what are those barriers?
What are their assets? What are they good at?
What kind of services do you feel would help them overcome the barriers to their goals?
If they have used mental health services in the past (or presently), what was helpful about these services? ☐NA What was not helpful about these services?
Is there a person or people (friends, relatives, etc.) you would like involved in your child's care?

Other Agency Involvement:

Please check all that apply. Give dates for past involvement with these agencies

AGENCY	PAST (dates, results)	PRESENT
Violence Intervention		
ACCES-VR		
Case Management		
Child Preventive Services		
Child Protective Services		
Court Involvement, please specify		
Families First		
HUD		
IDV Court		
Inpatient Mental Health Treatment (please list places and dates)		
Inpatient Substance Abuse Treatment (please list places and dates)		
Jail/Prison		
Mental Health Association		
Mountain Lake Services		
DPWDD		
Outpatient Mental Health Treatment		
Outpatient Substance Abuse Treatment (please list places and dates)		
Probation/Parole		
Public Health		
Social Services		
Stop Domestic Violence		
VA		
Victim's Assistance		
YAP		
Other		

ESSEX COUNTY MENTAL HEALTH SERVICES

Modified Simple Screening Instrument for Substance Abuse (MSSI-SA)
Self-Administered Form

Name _____ Date _____

Directions: The questions that follow are about your use of alcohol and other drugs, including prescription and over-the-counter medication/drugs. Your answers will be kept private. Mark the response that best fits for you.

Filling out this form assists us in identifying your needs and providing you with services.
Your answers on this form will not exclude you from services, care or treatment at this program.

Answer questions 1-13 in terms of your experiences in the past 6 months:

	Yes	No
1a. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants) 1b. Have you used prescription or over-the-counter medication/drugs? (Such as sleeping pills, pain killers, sedatives, or anti-anxiety medication like Valium, Xanax, or Ativan)		
2. Have you felt that you use too much alcohol or other drugs? (Other drugs also include prescription or over-the-counter medication more than recommended.)		
3. Have you tried to cut down or quit drinking or using alcohol or other drugs?		
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.)		

5. Have you had any health problems? Please check if you have:
   - ___ Had blackouts or other periods of memory loss?
   - ___ Injured your head after drinking or using drugs?
   - ___ Had convulsions, delirium tremens ("DTs")?
   - ___ Had hepatitis or other liver problems?
   - ___ Felt sick, shaky, or depressed when you stopped?
   - ___ Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?
   - ___ Been injured after drinking or using?
   - ___ Used needles to shoot drugs?

Please continue ⇒

ESSEX COUNTY MENTAL HEALTH SERVICES

Modified Simple Screening Instrument for Substance Abuse (continued)

During the past 6 months...

	Yes	No
6. Has drinking or other drug use caused problems between you and your family or friends?		
7. Has your drinking or other drug use caused problems at school or at work?		
8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.)		
9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?		
10. Are you needing to drink or use drugs more and more to get the effect you want?		
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?		
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break laws, sell things that are important to you, or have unprotected sex with someone?		
13. Do you feel bad or guilty about your drinking or drug use?		

The next questions are about your lifetime experiences.

	Yes	No
14. Have you ever had a drinking or other drug problem?		
15. Have any of your family members ever had a drinking or drug problem?		
16. Do you feel that you have a drinking or drug problem now?		

Thank you for filling out this questionnaire.

Date: _____

_____

(Signature of person completing this form)

Name _____ Age _____ Sex (Circle): Girl Boy

Today's Date (**write month, day and year**) _____ Grade in School _____

School _____ Teacher _____ Town _____

Below is a list of VERY SCARY, DANGEROUS, OR VIOLENT things that sometimes happen to people. These are times where someone was HURT VERY BADLY OR KILLED, or could have been. Some people have had these experiences, some people have not had these experiences. Please be honest in answering if the violent thing happened to you, or if it did not happen to you.

FOR EACH QUESTION:	**Check "Yes"** if this scary thing **HAPPENED TO YOU** **Check "No"** if it **DID *NOT* HAPPEN TO YOU**

1)	Being in a big earthquake that badly damaged the building you were in.	Yes [ ]	No [ ]
2)	Being in another kind of **disaster**, like a fire, tornado, flood or hurricane.	Yes [ ]	No [ ]
3)	Being in a bad **accident**, like a **very serious** car accident.	Yes [ ]	No [ ]
4)	Being in place where a **war** was going on around you.	Yes [ ]	No [ ]
5)	Being **hit, punched, or kicked very hard** at home. (**DO NOT INCLUDE** ordinary fights between brothers & sisters).	Yes [ ]	No [ ]
6)	Seeing a family member being **hit, punched or kicked very hard** at home. (**DO NOT INCLUDE** ordinary fights between brothers & sisters).	Yes [ ]	No [ ]
7)	Being **beaten up, shot at or threatened to be hurt badly** in your town.	Yes [ ]	No [ ]
8)	Seeing someone in your town being **beaten up, shot at or killed.**	Yes [ ]	No [ ]
9)	Seeing a **dead body** in your town (do not include funerals).	Yes [ ]	No [ ]
10)	Having an adult or someone much older touch your **private sexual body parts** when you did not want them to.	Yes [ ]	No [ ]
11)	Hearing about the **violent death or serious injury** of a loved one.	Yes [ ]	No [ ]
12)	Having **painful and scary medical treatment in a hospital** when you were very sick or badly injured.	Yes [ ]	No [ ]

Contact: UCLA Trauma Psychiatry Service
300 UCLA Medical Plaza, Ste 2232
Los Angeles, CA 90095-6968 (310) 206-8973
EMAIL: rpynoos@mednet.ucla.edu

13) **OTHER** than the situations described above, has **ANYTHING ELSE** ever happened to you that was **REALLY SCARY, DANGEROUS, OR VIOLENT?** Yes [ ] No [ ]

14) a) If you answered "YES" to only **ONE** thing in the above list of questions #1 to #13, place the number of that thing (#1 to #13) in this blank: # _____

b) If you answered "YES" to **MORE THAN ONE THING,** place the number of the thing that **BOTHERS YOU THE MOST NOW** in this blank: #_____

c) About how long ago did this bad thing (your answer to [a] or [b]) happen to you? _____

d) Please write what happened: _____

_____

_____

_____

_____

FOR THE *NEXT* QUESTIONS, please **CHECK [YES] or [NO]** to answer **HOW YOU FELT during or right after** the bad thing happened that you just wrote about in Question 14.

15) Were you scared that you would die?	Yes [ ]	No [ ]
16) Were you scared that you would be hurt badly?	Yes [ ]	No [ ]
17) Were you hurt badly?	Yes [ ]	No [ ]
18) Were you scared that someone else would die?	Yes [ ]	No [ ]
19) Were you scared that someone else would be hurt badly?	Yes [ ]	No [ ]
20) Was someone else hurt badly?	Yes [ ]	No [ ]
21) Did someone die?	Yes [ ]	No [ ]

22) Did you feel very scared, like this was one of your most scary experiences ever?	Yes [ ]	No [ ]
23) Did you feel that you could not stop what was happening or that you needed someone to help?	Yes [ ]	No [ ]
24) Did you feel that what you saw was disgusting or gross?	Yes [ ]	No [ ]
25) Did you run around or act like you were very upset?	Yes [ ]	No [ ]
26) Did you feel very confused?	Yes [ ]	No [ ]
27) Did you feel like what was happening did not seem real in some way, like it was going on in a movie instead of real life?	Yes [ ]	No [ ]

Here is a list of problems people sometimes have after very bad things happen. Please **THINK** about the bad thing that happened to you that you wrote about in Question #14 on the page 2. Then, **READ** each problem on the list carefully. **CIRCLE ONE** of the numbers (0, 1, 2, 3 or 4) that tells how often the problem has happened to you **in the past month**. Use the **Rating Sheet** on Page 5 to help you decide how often the problem has happened in the past month.

PLEASE BE SURE TO ANSWER ALL QUESTIONS

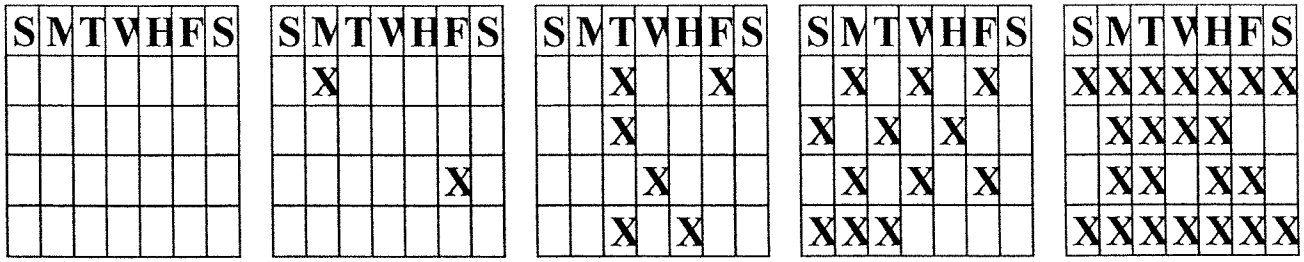
HOW MUCH OF THE TIME DURING THE PAST MONTH	None	Little	Some	Much	Most
1_{D4} I watch out for danger or things that I am afraid of.	0	1	2	3	4
2_{B4} When something reminds me of what happened, I get very upset, afraid, or sad.	0	1	2	3	4
3_{B1} I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I do not want them to.	0	1	2	3	4
4_{D2} I feel grouchy, angry or mad.	0	1	2	3	4
5_{B2} I have dreams about what happened or other bad dreams.	0	1	2	3	4
6_{B3} I feel like I am back at the time when the bad thing happened, living through it again.	0	1	2	3	4
7_{C4} I feel like staying by myself and not being with my friends.	0	1	2	3	4

HOW MUCH OF THE TIME DURING THE PAST MONTH	None	Little	Some	Much	Most
8_{C5} I feel alone inside and not close to other people.	0	1	2	3	4
9_{C1} I try not to talk about, think about, or have feelings about what happened.	0	1	2	3	4
10_{C6} I have trouble feeling happiness or love.	0	1	2	3	4
11_{C6} I have trouble feeling sadness or anger.	0	1	2	3	4
12_{D5} I feel jumpy or startle easily, like when I hear a loud noise or when something surprises me.	0	1	2	3	4
13_{D1} I have trouble going to sleep or I wake up often during the night.	0	1	2	3	4
14_{AF} I think that some part of what happened is my fault.	0	1	2	3	4
15_{C3} I have trouble remembering important parts of what happened.	0	1	2	3	4
16_{D3} I have trouble concentrating or paying attention.	0	1	2	3	4
17_{C2} I try to stay away from people, places, or things that make me remember what happened.	0	1	2	3	4
18_{B5} When something reminds me of what happened, I have strong feelings in my body, like my heart beats fast, my head aches, or my stomach aches.	0	1	2	3	4
19_{C7} I think that I will not live a long life.	0	1	2	3	4
20_{AF} I am afraid that the bad thing will happen again.	0	1	2	3	4

FREQUENCY RATING SHEET

HOW OFTEN OR HOW MUCH OF THE TIME DURING THE PAST MONTH, THAT IS SINCE _____, DOES THE PROBLEM HAPPEN?

0	1	2	3	4
NONE	**LITTLE**	**SOME**	**MUCH**	**MOST**



NEVER	TWO TIMES A MONTH	1-2 TIMES A WEEK	2-3 TIMES EACH WEEK	ALMOST EVERY DAY

Date: _____ Name/ID: _____

RCADS – D (Child Version)

Instructions: **Please put a circle around the word that shows how often each of these things happen to you. There are no right or wrong answers.**

1. I feel sad or empty ..... Never Sometimes Often Always

2. Nothing is much fun anymore ..... Never Sometimes Often Always

3. I have trouble sleeping ..... Never Sometimes Often Always

4. I have problems with my appetite ..... Never Sometimes Often Always

5. I have no energy for things ..... Never Sometimes Often Always

6. I am tired a lot ..... Never Sometimes Often Always

7. I cannot think clearly ..... Never Sometimes Often Always

8. I feel worthless ..... Never Sometimes Often Always

9. I feel like I don't want to move ..... Never Sometimes Often Always

10. I feel restless ..... Never Sometimes Often Always

Individual's Name (First / MI / Last):	Record#:
Date of Admission:	Date:

What are your goals in life?

Is there anything that stops you from pursuing those goals? ☐ Yes ☐ No - if yes, what are those barriers?:

What are your assets? What are you good at?

What do you do that makes life valuable?

What kind of services do you feel could help you overcome the barriers to your goals?

If you have used mental health services in the past (or presently), what was helpful about those services? ☐ NA

What was not helpful about those services?

Is there a person or people (friends, relatives, etc.) you would like involved in your care?