

Instructions to referring clinician:

Attach assessment completed within sixty (60) days of request, Releases of Information as necessary, progress notes for thirty (30) days, discharge summary if appropriate. Please have parent sign permission and complete attached demographic.

Does an assessment need to be updated or conducted urgently
Checking this box will prompt MCCFL clinical staff to schedule an immediate (within five (5) working days) an assessment.

The following to be completed by Screener:

	Date	CASII Rater	CASII Rater
Complete referral packet received.			
CASII review team start date.			
CASII review team completion.			

- Print CASII, attach to packet, give to Children’s Clinical Supervisor, who will file in chart
- Supervisor give copy of CASII to Abby

BEHAVIORAL INDICATOR CHECKLIST Completed by:

Child/Adolescent Current Presentation:

Yes No

Child/Adolescent Current Presentation:	Yes	No
Risk of harm to self or others:		
1. Current suicidal ideation, gestures, or threats.		
2. Has suicidal plan or accessibility to means.		
3. Current harm or hurting of others.		
4. Has plan to hurt others.		
At-risk for out of home placement:		
1. Exhibits property damage or fire-setting behavior.		
2. History of multiple out of home placements due to behavioral disorders or mental illness.		
3. Placed in relative care.		
4. Placed in foster care.		
5. Current criminal behavior or legal offenses.		
6. Caregiver has difficulty with providing adequate and appropriate care.		
School problems due to mental health disorder:		
1. Is truant or not attending school.		
2. Has been expelled or suspended.		
3. Behavioral problems occur frequently.		
4. IEP or special education classes has not been effective.		
History of outpatient services:		
1. Crisis intervention services has not resulted in stabilization.		
2. Outpatient services has not been effective.		
3. Community-based services have not been effective.		
4. History of unsuccessful day treatment.		
5. Involved with mental health and at least two other agencies.		
History of emergency and/or psychiatric hospitalization:		
1. Frequent episodes of mental health emergency/crisis intervention.		
2. Has been hospitalized in the past year.		
3. History of residential treatment/sub-acute care.		

MID-COLUMBIA CENTER FOR LIVING

CONSENT TO CONDUCT CHILD/ADOLESCENT SERVICE INTENSITY INSTRUMENT (CASII)

Name of Child: _____	DOB: _____
Name of Parent(s)/Guardian: _____	_____
Address: _____	Phone: _____
City: _____	State: _____ Zip: _____

I understand that my child has been referred for the Intensive Community Based Treatment and Support Services (ICTS) and that a screening called the Child/Adolescent Service Intensity Instrument (CASII) needs to be conducted to determine if my child meets the criteria to receive these services. The CASII screening may involve an interview of my child and the information will be kept completely confidential, unless I provide a signed Authorization to Disclose Information form. I also acknowledge receiving a copy of the Notice of Privacy Practices, which further informs me about the laws regarding my child's protected health information.

I understand that participation in the CASII screening is voluntary and hereby give my permission for my child to participate in the CASII screening.

Parent/Guardian signature: _____

Date: _____

DEMOGRAPHIC INFORMATION

<input type="checkbox"/> W - White	<input type="checkbox"/> 01 - Alone/Independent
<input type="checkbox"/> B - Black	<input type="checkbox"/> 02 - Spouse/Significant Other
<input type="checkbox"/> M - Hispanic:Mexican	<input type="checkbox"/> 03 - Parents/Relatives
<input type="checkbox"/> C - Hispanic:Cuban	<input type="checkbox"/> 06 - Friends / Others
<input type="checkbox"/> P - Hispanic:PuertoRican	<input type="checkbox"/> 04 - Non Relative Foster Home
<input type="checkbox"/> H - Hispanic:Other	<input type="checkbox"/> 05 - Institution
<input type="checkbox"/> N - Native American	<input type="checkbox"/> 97 - Transient / Homeless
<input type="checkbox"/> A - Alaskan Native	<input type="checkbox"/> 07 - Skilled Nursing Facility
<input type="checkbox"/> S - Asian: Southeast	<input type="checkbox"/> 09 - Residential Treatment Fac/Home
<input type="checkbox"/> I - Asian:Pacific Islander	<input type="checkbox"/> 16 - Room/Board
<input type="checkbox"/> D - Native Hawaiian/Other Pac Isle	<input type="checkbox"/> 21 - Treatment Foster Care
<input type="checkbox"/> O - Other Race (AODG only)	<input type="checkbox"/> 27 - Other
	<input type="checkbox"/> 28 - Other Residential Fac/Group Home

MARITAL STATUS:	EMPLOYMENT STATUS:
<input type="checkbox"/> N - Never Married	<input type="checkbox"/> 1 - Full Time/35+Hours per Week
<input type="checkbox"/> M - Married	<input type="checkbox"/> 2 - Part Time/17-34 Hours per Week
<input type="checkbox"/> W - Widowed	<input type="checkbox"/> 3 - Irregular/17 Hours per Week
<input type="checkbox"/> D - Divorced	<input type="checkbox"/> 4 - Not Employed, but looking
<input type="checkbox"/> S - Separated	<input type="checkbox"/> 5 - Not Employed, not looking
<input type="checkbox"/> L - Living as Married	

EDUCATION:	OCCUPATIONAL:
Current Grade in School: _____	<input type="checkbox"/> 00 - Employable or Working
School: _____	<input type="checkbox"/> 01 - Student
# of Years Completed: _____	<input type="checkbox"/> 09 - Unknown
Enrolled in School/Training: Y <input type="checkbox"/> N <input type="checkbox"/>	
Currently in Special Ed: Y <input type="checkbox"/> N <input type="checkbox"/>	

TOTAL GROSS MONTHLY INCOME (IMMEDIATE FAMILY ONLY) \$ _____
Enter # of people depending on income in each age group 0-5 _____ 6-17 _____ 18-64 _____ 65+ _____
Primary Source of Income: (check one) Wages/Salary _____ Public Assistance/Welfare _____
Other _____ None _____ Medicaid # _____