In-Home Family Treatment (H2011)
Screening Instrument
Ver. 1/2007

Child's Name: _____ **Referring Agency:** _____

Child's DOB: _____ **FC/JJA Case Manager:** _____

FC/JJA Case Manager Phone #: _____

Name of person completing this form: _____

1. Has the child been determined to be SED? YES ☐ NO ☐
If YES, proceed to next question.
If NO, then the child is not eligible for this service.

2. Is the youth experiencing functional impairment as a result of their mental illness in their current placement that requires a service to remedy the family problems which contribute to the symptoms of the mental illness or their functional impairment?
YES ☐ NO ☐

3. List the specific functional impairments that the youth is exhibiting (as it relates to their mental illness) that it is believed can best be impacted by In-Home Family Treatment:

_____

4. List the specific family problems that are believed to be contributing to this child's emotional disturbance:

_____

5. List previously received mental health services that were not successful in resolving the issues listed in #3 and #4:

_____

6. Has the family that the child is currently living with received Family Therapy? If yes explain the results of that intervention – if no explain why clinic based services are not being tried first) ☐ YES ☐ NO

_____

7. Date of most recent CAFAS Scores: _____
(must be less than 30 days old- follow Up CAFAS should utilize a 30 day time frame for rating the criteria):

Total Score:	___		
Home:	___	**Self-Harm:**	___
School:	___	**Substance Use:**	___
Behavior towards others:	___	**Thinking:**	___
Community:	___		
Moods:	___		

8. Please explain why In-Home Family Treatment is believed to be the most effective treatment intervention at this time and what result it is believed this intervention will achieve:

_____

FOR CMHCCC USE ONLY:

☐ **Request for Initial Authorization has been approved for** _____ **units**

☐ **Request for Initial Authorization has not been approved for the following reasons:**

_____

☐ **Other Treatment Recommendations:**

_____

Date: _____ **CMHC QMHP:** _____