FAMILY INSIGHT, P.C.
Enhancing the well-being of individuals and families

Client Name: _____ Medicaid #: _____ HBS MHSB IIH Crisis Pvt Ins

Lauris ID #: _____ Service Type: _____

(Please Print) *(HBS/Private Ins.)* *(Ex: Mentoring, IIH, Assessment, Level C, etc.)*

***DATE, TIMES, AND HOURS MUST BE FILLED OUT PRIOR TO CLIENT SIGNATURE - SIGNATURE IS TO CONFIRM SESSION DATE AND TIME**

Date: M/D/Y	Session Location: *Please be specific*	Time In: Time Out:	# Hours	Those Involved or/present	Comments *Please do not leave blank*	Signature of Client/Parent/Guardian **DO NOT SIGN IF DATE AND TIMES ARE NOT FILLED OUT**

"I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."

Staff Signature with Credentials: _____

Revised 2.1.2020

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Authorization for Release of Information

I,_____(Client name or Representative), born on_____(DOB) hereby authorizes Family Insight (FI) to exchange information with:

Name of individual and/ or organization: _____

Address/Phone Number: _____

For the purposes:(specify) _____

This information includes (check all that apply):

- ☐ Medical Records
- ☐ Educational/Academic Records
- ☐ Psychiatric Evaluation
- ☐ Psychological Evaluation
- ☐ Court Report
- ☐ An on-going exchange of information
- ☐ Urine Screen/Breathalyzer Results
- ☐ Other (describe below)
- ☐ Neurological Evaluation
- ☐ Behavioral Reports
- ☐ Teacher Reports
- ☐ Treatment/Discharge Summary
- ☐ Substance Abuse Evaluation
- ☐ Past Services (Verbal Exchange or Reports)
- ☐ Permitted to sign Contact Logs to verify visits

This authorization is valid from_____(Date) to_____(Date), unless revoked by the undersigned.

Consent Signature(s)

Above Named Client	Date
Parent/Guardian/Authorized Representative	Date
Prepared and witnessed by FI Staff Member	Date

Revocation Signature(s)

Above Named Client	Date
Parent/Guardian/Authorized Representative	Date
Prepared and witnessed by FI Staff Member	Date

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient.

Client Name:
Client #:

My SNAP Assessment for Recovery

This worksheet will help us talk with you about your mental health treatment here at Cincinnati VAMC. There are four parts for you to share with us about your **S**trengths, **N**eeds, **A**bilities and **P**references. Please check and/or list the items which best fit you at this time.

What personal qualities do you have which we can build upon in treatment?

- Open minded
- Friendly
- Creative
- Good Listener
- Quick Learner
- Good Grooming
- Organized
- Takes personal responsibility
- Strong personal or spiritual values
- Independent
- Assertive
- Hard Worker
- Able to learn from my experiences
- Can collaborate/ work with others
- Good Problem Solver
- Good Decision Maker
- Dependable
- Motivation
- Good health
- Other (Please List)

_____

NEEDS

What would help you achieve your goals? Please, check your most important needs.

(Prioritize your top three)

- Increase my knowledge of resources that provide me with support
- Referral to resources for job training or education
- Access to medical care for health related concerns
- Staying in a sober environment to help me not use drugs and or alcohol
- Gain more knowledge and understanding about:
  - My mental health diagnosis
  - My medication(s)
  - My symptoms / behaviors related to my mental health diagnosis
- Get help to stop smoking
- Learn how to empower myself to take a more active role in my treatment
- Increasing effective communication skills to improve my relationships with others
- Learn how to talk about my concerns/issues/feelings
- Practice my coping skills in a safe environment
- Learn more about effective coping skills related to:
  - Improving my sleep
  - Reducing anxiety and using relaxation
  - Managing my depression
  - Leisure skills
  - Organizing daily activities
  - Managing anger
  - Mood Regulation
  - Improving reality-based thinking
  - Eating Healthy

Other (Please List)

_____

Abilities

What skills do you possess?

- Basic ability to read and write
- Computer knowledge and skills
- Ability to work effectively with others
- Knowledge or tools that I use to help me manage my emotions
- Ability to have positive relationships with others
- Ability to make healthy decisions about my life
- Job Skills _____
- Education / Training_____
- Leisure Skills_____
- Ability to manage my time and structure my daily activities
- Other (Please List)

Preferences

How do you want your treatment?

- I prefer my family or friends to be involved in my treatment
- I would like to have a family meeting
- I learn new information better:
  - Face to face
  - Hands on instruction and practice
  - Reading written material
    - Alone
    - In discussion with others
  - Sharing information in a group of my peers

I would like to live:

- Independently, on my own
- Independently, with community support
- With others
- Other ideas I have about my living situation (Please List)

_____

I am interested in learning more about

- Outpatient programming
- Community resources
- Other areas of interest (Please List)

Family Insight, P.C.
Comprehensive Needs Assessment

□ **Initial** □ **Update** □ **Annual Re-Assessment**

Client Name:_____ **Assessment Date:** _____

Age:_____ **DOB:**_____

Address: _____
Street **City/County** **State** **Zip**

□ **Private Residence** □**Adult Care Residence** **Name of ACR:**_____

Phone:_____ **Marital Status:**_____ **SSN:**_____

Physical Description:

Sex_____ **Race**_____ **Height** **Weight**_____ **BMI**_____

Hair Color _____ **Eye Color**_____

Parent/Guardian Name:_____ **Relationship to Client:** _____

Address: _____
Street **City/County** **State** **Zip**

Phone:_____ **Phone:**_____
Home **Work**

Emergency Contact:_____ **Relationship to Client:** _____

Address: _____
Street **City/County** **State** **Zip**

Phone:_____ **Phone:**_____
Home **Work**

Client's Medicaid #:_____ **ID#**_____

Client's Funding Source: _____

Referred By:_____ **Agency:** _____

Relationship to Client: _____

Referral Source's Phone:_____

Client is currently taking medications _____ Current Permission to Restrain: _____

:

Presenting Issues/Reason for Referral(Include a narrative of the behaviors exhibited in major life activities by the client over the past 30 days. Indicate frequency, severity and duration of behavioral health symptoms that warrant the level of care associated with community based services. Identify precipitating events/stressors, relevant history & specific reason for being at risk for out of home placement)

Client Stengths, Needs, Abilities and Preferences (SNAP)

List support system along with family strengths and coping skills, entitlements, and other relevant resources:_____

Significant Cultural or Religious Beliefs:_____

Ability to complete independent daily living skills (personal care/hygiene, level of independence):_____

Barriers to Strengths/Resources: _____

Client's Challenges (unhealthy coping skills, area daily functioning that exasperate symptoms): _____

Medical Profile

PCP Name:_____Phone Number: _____

Address_____ Fax Number: _____

Psychiatrist Name:_____Phone Number: _____

Address_____ Fax Number:_____

Current Medical Problems, Illnesses, Injuries & Complaints

Current physical complaints, significant past &present medical problems, illnesses and injuries*(add boxes as needed)*	Physician	Prescribed Treatment	Currently Receiving Treatment Yes or No

Allergies? ☐ No ☐YesIf yes, indicate allergies & treatment (include allergies to food, medications, and environmental causes) _____

Nutritional Needs? ☐No ☐Yes _____

Communicable Diseases? ☐No ☐Yes _____

Past Serious Illnesses or Hospitalizations? ☐ No ☐ Yes _____

Restrictions on Physical Activities/Fall Risk? ☐No ☐Yes_____

Fall Risk Plan (see Fall Risk Assessment uploaded into the EHR):
Fall Risk Assessment Score: ☐ 6-13 Moderate ☐Over 14 High
Recommendations: _____

Current Medications *(add boxes as needed)*	**Dosage/Frequency**	**Prescriber**	**History of Compliance Issues**	**Reason for Medication**

Previous Medications: _____

Over the Counter Medications: _____

Efficacy of current and previous used medications: _____

Behavioral Health History/Hospitalizations Give details of any mental health related hospitalizations and diagnoses (include dates, locations reason for care, reason for discharge, continuing care recommended and outcome/results).

Name of Hospital/Agency (include CSU/PHP) *(add boxes as needed)*	**Intervention Provided/Type of Service Received**	**Dates**	**Result/Response to Treatment**

List any psychological, psychiatric, or neurological evaluation given or scheduled and all psychiatric history and responses to various providers

Name of Agency/Provider *(add boxes as needed)*	**Type of Evaluation**	**Date**	**Evaluation Finding/Recommendations**

Other:			
Other:			

List the types of interventions that have been provided to the child/family; include the date of the interventions and the name of the provider; list family members and the dates and the types of treatment that family members either are currently receiving or have received in the past: _____

Previous Interventions Include the types of interventions that have been provided to the individual. Include the date of the mental health interventions and the name of the mental health provider.

Mental Health Provider*(add boxes as needed)*	**Dates of Service**	**Interventions Provided**	**Response to Treatment/Outcome**
	Click here to enter text.		

Developmental History

Describe client as an infant &toddler:_____

Typical affect and level of irritability as infant/toddler:_____

Interest in being held, fed, played with and parents ability to provide these: _____

Parents feelings and thought about them as infant and toddler:_____

Medical/physical complications or illnesses:_____

Was individual significantly delayed in reaching any developmental milestones (crawling, walking, talking, toileting)? _____

Discipline/Child management techniques used in the family & parenting style: _____

Describe any developmental issues:_____

Were there any significant complications at birth? _____

List any significant complications at birth, any trauma, abuse, and neglect as toddler/child: _____

Is there a need for assistive technology? Does the client currently use any assistive technology: (describe the technology need and usage)_____

Family History& Relationships

Developmental disabilities, mental health & substance use related diagnoses & treatment (include name of family member, diagnosis, type of drug, frequency & duration)

Serious illnesses & chronic conditions of parents/siblings/others in the household (include name of family member) _____

Social and Family Support System (positive supports, conflicts, relationships & interactions that affect client)_____

Current Living Situation

Are you living in a supported environment: ☐ Yes ☐ No

If yes, what type of housing environment _____

Name	Relationship to client	Age	In Household? (Y or N)	Mental Health or Substance Abuse DX/Treatment? Yes or No If yes, describe

Previous Living Situation and/or Family History of Housing(list type of home& duration: house, apartment, trailer, independent living facility, nursing home, assisted living facility, etc.)

Describe Daily Routine and Structure

Financial Benefits & Resources

Ability to Access Services

Risk Assessment

Suicide Potential☐ Yes ☐ No

☐ HX of attempts ☐current attempts ☐ ideation ☐ intent ☐ planvague

☐ plan defined ☐ means ☐ active psychosis ☐ current substance abuse

Describe:

If Applicable, indicate Safety Plan: *(if Yes is checked above this section will be required and must be filled out)*

Potential Harm to Others ☐ Yes ☐ NO

☐ HX of assault ☐ assault/attempted ☐ ideation ☐ intent ☐ planvague

☐ plan defined ☐ means ☐ active psychosis ☐ current substance abuse

Describe:

If Applicable, how was intended victim warned? *(if Yes is checked above this section will be required and must be filled out)*

Indicate Safety Plan:*(if Yes is checked above this section will be required and must be filled out)*

Self Harming Behavior ☐ Yes ☐ NO

☐ HX of attempts ☐current attempts ☐ ideation ☐ intent

☐ means ☐ active psychosis ☐ current substance abuse

Describe:

If Applicable, indicate Safety Plan:*(if Yes is checked above this section will be required and must be filled out)*

History of Physical, Sexual, and/or Psychological Abuse, Neglect, Domestic Violence, Military Sexual Trauma (MST), exposure to drug/paraphernalia in the home(Indicate CPS/APSinvolvement, if abuser was charged/convicted, removal from home, etc. Please note whether the abuse/trauma was experienced, witnessed, or both)

Have Health, Safety and Welfare issues been identified with this client?☐Yes ☐No

If "Yes", has a CPS/APS referral been made? ☐Yes ☐No*If yes is checked above this section must be filled out)*

Note contact name, date, & disposition: _____

If "No", what interventions have been made to address this concern?_____

Drug & Alcohol Profile: Describe substance use and abuse by the individual; specify the type of substance with frequency and duration of usage.

Drug of Choice	Onset of Use	Current/Last Use	Frequency of Use	Previous TX Interventions

Describe impact on daily functioning, mental status & interpersonal relationships: Click here to enter text.

Does this individual require a more intensive substance abuse evaluation (current use/extensive history)? ☐ Yes ☐ No

Was LMHP/CSAC staff contacted regarding substance abuse assessment? ☐ Yes ☐ No

Staff Contacted: _____

Educational Background:

School Attended (include City, State)	Grade	Years Attended	IEP (Y or N)	Behaviors in School	# Suspensions/Expulsions

Comments (include details regarding current grade, special ed., IEP, child study, Therapeutic Day Treatment, One to One, Alternative School, Home Bound, academic performance, behaviors/disciplinary actions, attendance, peer relationships, literacy level):_____

Employment and Vocational Background(Present/Past Occupations& Job Performance)_____

Military Background

Legal Status

Pending Legal Charges:☐ Yes ☐ No If yes, complete the following information:

Nature of charges: _____

Date of hearing:_____Court of Jurisdiction: _____

History of Legal Charges/Convictions:☐ Yes ☐ No If yes, complete the following information:

Nature of charges: _____

Date of hearing:_____Court of Jurisdiction:_____

Client served sentence: ☐ Yes ☐ No Probation/Parole: ☐ Yes ☐ No

Probation/Parole Officer (name & contact info): _____

Care Coordination

Authorized Representative:☐ Yes ☐ No

Name & Contact:_____

(if Yes is checked above this section will be required and must be filled out)

Representative Payee:☐ Yes ☐ No

Name & Contact: _____

(if Yes is checked above this section will be required and must be filled out)

Legal Guardian:☐ Yes ☐ No

Name & Contact: _____

(if Yes is checked above this section will be required and must be filled out)

NGRI Status(Not Guilty by Reason of Insanity):☐ Yes ☐ No

Court Jurisdiction, Agency, CM Name & Contact: _____

(if Yes is checked above this section will be required and must be filled out)

CASA Worker: ☐ Yes ☐ No

Name & Contact: _____

(if Yes is checked above this section will be required and must be filled out)

List relevant contacts to include Department of Social Services, Guardian Ad Litem, or local community services board with individual and/or family (provide detailed description with dates, contact person, and reason for involvement)

Has the local CSB been contacted to determine if Mental Health Case Management services are being provided? ☐Yes ☐No
Comments:

Is the client receiving MH or SA Case Management Services through the local CSB?☐ Yes ☐ No If yes, state Agency, Case Manager's Name & phone #: _____
If no, was a referral been made to the CSB for case management services with the consent of parent or legal guardian if necessary: _____
If yes, date of referral: _____
If no, why not: _____

Mental Status Exam

Appearance: ☐ WNL	☐ Poor	☐ Unkempt	☐ Poor Hygiene	☐ Bizarre	☐ Tense
Behavior/ Motor Disturbance: ☐ WNL	☐ Agitation	☐ Guarded	☐ Tremor	☐ Manic	☐ Impulse Control
Orientation: ☐ WNL	☐ Disoriented	☐ Time	☐ Place	☐ Person	☐ Situation
Speech: ☐ WNL	☐ Pressured	☐ Slowed	☐ Soft/Loud	☐ Impoverished	☐ Slurred
Mood:☐WNL	☐ Depressed	☐ Angry/Hostile	☐ Euphoric	☐ Anxious	☐ Anhedonic
Range of Affect: ☐ WNL	☐ Constricted	☐ Flat	☐ Labile	☐ Inappropriate	
Thought Content: ☐ WNL	☐ Delusions	☐ Grandiose	☐ Ideas of Reference	☐ Paranoid	☐ Obsessions
Thought Process: ☐WNL	☐ Loose Associations	☐ Flight of Ideas	☐ Circumstantial	☐ Blocking	☐ Tangential
Perception:☐ WNL	☐ Hallucinations	☐ Auditory	☐ Visual	☐ Olfactory	☐ Illusions
Memory: ☐ WNL	☐ Impaired	☐ Recent	☐ Remote	☐ Immediate	
Appetite: ☐ WNL	☐ Poor	☐ Increased	☐ Decreased	☐ Weight:	☐ Loss
Sleep:☐ WNL	☐ Hypersomnia	☐ Onset Problem	☐ Maintenance Problem		
Insight: ☐ WNL	☐ Blaming	☐ Little	☐ None	☐ Externalized	☐ Introspective
Estimated Intellectual/ Functional Capacity	☐ Above Avg.	☐ Average	☐ Below Avg.	☐ Diagnosed ID	

Attitude toward Assessor: _____

Mental Status Exam Scores &Comments (explain any findings other than WNL):

Was an initial Client Outcome Survey completed by the assessor at the time of assessment? ___

Interpretive Summary

Client's Diagnosis (include ICD-10 codes) Dropdown box w/ codes

Primary Dx:

Secondary Dx:

Tertiary Dx:

Clinical Findings and Recommendations (client presentation/interaction during assessment, additional clinical issues to be addressed that were not identified above, identify any co-occurring disabilities,identify causes current treatment needs, discuss treatment options & potential outcomes & potential barrier to treatment progress, justify the diagnosis, specify how and why the client meets the criteria for the service(s) you are recommending):

Client/Parent Preferences for Treatment Services:

Recommended Weekly Service Hours:_____to _____

Recommended Care & Treatment Goals (note how SA Treatment will be integrated into care on ISP if applicable):

Service Coordination (insurance care coordinator, state Agency, name, position & recommended frequency of contact):

All Other Recommendations (housing, medication, employment, etc.)

- ☐ Intensive In-Home (IIH)
- ☐ Home Based Services (HBS)
- ☐ Mental Health Skill Building (MHSB)
- ☐ Outpatient Therapy (OP) Indicate MH or SA:
- ☐ Intensive Outpatient (IOP)
- ☐ Crisis Stabilization

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Mental Status Exam

Cheat Sheet

Appearance:

WNL (within normal limits)
Poor
Poor Hygiene - *uncombed hair, dirty clothing, odor*
Bizarre - *several layers of clothing on, inappropriate*
Tense
Rigid

Behavior/Motor Disturbance:

Agitation - *increased body movements (pacing)*
Guarded
Tremor
Manic - *elevated arousal and energy level*
Impulse control
Psychomotor retardation - *significant slowing of speech and body movements*
WNL

Orientation:

WNL - within normal limits
Disoriented - *confused*
Time - *they are aware of the date and time*
Place - *they know where they are*
Person - *they know who you are, they are*
Situation - *they are aware of the situation*

Speech:

WNL
Pressured - *speaks fast with few pauses between words*
Slowed

Soft/Loud
Impoverished - *deprived of*
Slurred
Other

Mood:

WNL
Depressed
Angry/Hostile
Euphoric - *feeling great, as if they just won the lottery*
Anxious
Anhedonic - *lack of pleasure*
Withdrawn

Range of Affect:

WNL
Constricted
Flat - *absence of affective expression*
Labile - *unpredictable shifts in emotional state*
Inappropriate - *expressed emotions not congruent with thoughts*

Thought Content:

WNL
Delusions - *false belief*
Grandiose
Ideas of Reference
Paranoid - *suspicious*
Obsessions - *ideas that are intrusive*
Phobias - *specific fear and is avoided; known as irrational*

Thought Process:

WNL
Loose Associations - frequent lapses in connections between thoughts
Flight of ideas - *flow of thoughts is rapid however connections are there*
Circumstantial - *inability to answer a question without giving excessive, unnecessary detail*
Blocking - *loses his/her train of thought*
Tangential - *suddenly changes subject and never returns to it*

Preservation - *repetitive thoughts or actions*

Perception:

WNL
Hallucinations - *see, taste, feel, hear, smell things that are not there*
    Auditory - *hear*
    Visual - *see*
    Olfactory - *smell*
Illusions - *misinterpretation of a sensory stimulus* Tactile - *Perception of feeling by touch*

Memory:

WNL
Impaired
Recent - *immediate past*
Remote - *distant past*
Immediate - *the first 15-30 seconds*

Appetite:

WNL
Poor
Increased
Decreased
Weight
Loss
Gain

Sleep:

WNL
Hypersomnia - *excessive sleepiness during the day* Onset problem - *since the beginning*
Maintenance problem

Insight:

WNL
Blaming
Little
None
Externalized
Introspective

Magellan HEALTHCARE℠

You may use this printable version of the ACEs to record responses during your face-to-face assessment with the member. To score the ACEs, you **must** fill in your responses into the ACEs scoring tool found on the Magellan of Virginia website. Please attach the completed ACEs scoring tool to your IACCT assessment (90889) submission.

Item #	C-ACEs only Ages 1-11	Response Choices		
1	**In the past year**, did you worry that your food would run out before you got money or Food Stamps to buy more?	Never	Sometimes	Often
2	**In the past year**, have you felt afraid of your partner?	No	No Partner	Yes
3	**In the past year**, have you thought of getting a court order for protection?	No	No Partner	Yes
4	Has your child **ever** witnessed adults in the home hitting, slapping, kicking or physically threatening each other?	No	Unsure	Yes
5	Has your child **ever** lived with a parent or other adult who often hit, slapped or kicked the child?	No	Unsure	Yes
6	Has your child **ever** lived away from home for more than a month?	No	Unsure	Yes
7	Do you feel your child is difficult to take care of?	Never	Sometimes	Often
8	Do you swear at or insult your child?	Never	Sometimes	Often
9	Do you need to hit/spank your child?	Never	Sometimes	Often
10	Are you currently living with a spouse or partner?	Yes	Unsure	No

11	Are your child's parents separated, divorced, or not living together?	No	Unsure	Yes	
12	Did your child **ever** live with anyone who went to prison, jail or other correctional facility?	No	Unsure	Yes	
13	Do you have friends or family who help take care of your child?	Often	Sometimes	Never	
14	Does your family look out for each other, feel close to each other and support each other?	Often	Sometimes	Never	
15	Over the past 2 weeks, how often have you been bothered by any of the following problems?				
	A1. Little interest or pleasure in doing things	Not at all	Several Days	More than half the days	Nearly every day
	A2. Feeling down, depressed, or hopeless	Not at all	Several Days	More than half the days	Nearly every day
	B1. Feeling nervous, anxious or on edge	Not at all	Several Days	More than half the days	Nearly every day
	B2. Not being able to stop or control worrying	Not at all	Several Days	More than half the days	Nearly every day
16	Did your child **ever** live with anyone who was depressed, mentally ill or suicidal?	No	Unsure	Yes	
17	On any single occasion, during the past three months, have you had **more than 4 drinks** containing alcohol?	No	Unsure	Yes	
18	Does your child spend time with anyone who uses drugs or drinks too much alcohol?	No	Unsure	Yes	
19	Did your child **ever** live with anyone who had a problem with drugs or alcohol?	No	Unsure	Yes	

20	Has your child ever been touched, or asked to touch, an adult or someone at least 5 years older sexually?	No	Unsure	Yes
21	Do you have a high school degree?	Yes	Unsure	No

Magellan HEALTHCARE℠

You may use this printable version of the ACEs to record responses during your face-to-face assessment with the member. To score the ACEs, you **must** fill in your responses into the ACEs scoring tool found on the Magellan of Virginia website. Please attach the completed ACEs scoring tool to your IACCT assessment (90889) submission.

Item #	C-ACEs only Ages 12-17	Response Choices		
1	**In the past year**, did you or your family worry that your food would run out before you got money or Food Stamps to buy more?	Never	Sometimes	Often
2	**In the past year**, have you felt afraid of someone you were dating?	No	Not Dating	Yes
3	Have you ever witnessed adults in the home hitting, slapping, kicking or physically threatening each other?	No	Unsure	Yes
4	Did you **ever** live with anyone who often shouted or yelled at you?	No	Unsure	Yes
5	Did you **ever** live with anyone who acted in a way that made you feel afraid?	No	Unsure	Yes
6	Did a parent or other adult **ever** hit you so hard that you had marks or were injured?	No	Unsure	Yes
7	Have you **ever** lived away from home for more than a month?	No	Unsure	Yes
8	Are your parents separated, divorced, or not living together?	No	Unsure	Yes
9	Has your parent or anyone you **ever** lived with went to prison, jail or other correctional facility?	No	Unsure	Yes
10	Do you feel that **no one** in your family loves you or thinks that you are important or special?	Never	Sometimes	Often

11	Does your family look out for each other, feel close to each other and support each other?	Often	Sometimes	Never
12	Did you **ever** live with anyone who was depressed, mentally ill or suicidal?	No	Unsure	Yes
13	Do you spend time with anyone who uses drugs or drinks too much alcohol?	No	Unsure	Yes
14	Did you **ever** live with anyone who had a problem with drugs or alcohol?	No	Unsure	Yes
15	Have you **ever** been touched, or asked to touch, an adult or someone at least 5 years older sexually?	No	Unsure	Yes
16	Does your primary caregiver (parent or guardian) have a high school degree?	Yes	Unsure	No

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COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

	Past month	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***	☐	☐
2) ***Have you actually had any thoughts of killing yourself?***	☐	☐
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** E.g. *"I thought about taking an overdose, but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."*	☐	☐
4) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to *"I have the thoughts, but I definitely will not do anything about them."*	☐	☐
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***	☐	☐
	YES	**NO**
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***Was this within the past three months?***	☐	☐

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS) Screen Version-Recent
Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann

Client Name: _____

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COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)

Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann

SUICIDAL IDEATION		
Ask questions 1 and 2. If both are negative, proceed to "Suicidal Behavior" section. If the answer to question 2 is "yes", ask questions 3, 4 and 5. If the answer to question 1 and/or 2 is "yes", complete "Intensity of Ideation" section below.	**Lifetime: Time He/She Felt Most Suicidal**	**Past 1 month**
1. Wish to be Dead Subject endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?*** If yes, describe:	**Yes No**	**Yes No**
2. Non-Specific Active Suicidal Thoughts General non-specific thoughts of wanting to end one's life/die by suicide (e.g., *"I've thought about killing myself"*) without thoughts of ways to kill oneself/associated methods, intent, or plan during the assessment period. ***Have you actually had any thoughts of killing yourself?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes No**
3. Active Suicidal Ideation with Any Methods (Not Plan) without Intent to Act Subject endorses thoughts of suicide and has thought of at least one method during the assessment period. This is different than a specific plan with time, place or method details worked out (e.g., thought of method to kill self but not a specific plan). Includes person who would say, *"I thought about taking an overdose but I never made a specific plan as to when, where or how I would actually do it...and I would never go through with it."* ***Have you been thinking about how you might do this?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes No**
4. Active Suicidal Ideation with Some Intent to Act, without Specific Plan Active suicidal thoughts of killing oneself and subject reports having some intent to act on such thoughts, as opposed to *"I have the thoughts but I definitely will not do anything about them."* ***Have you had these thoughts and had some intention of acting on them?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes No**
5. Active Suicidal Ideation with Specific Plan and Intent Thoughts of killing oneself with details of plan fully or partially worked out and subject has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?*** If yes, describe:	**Yes** ☐ **No** ☐	**Yes No**

Client Name:_____ C-SSRS

Client #: _____

INTENSITY OF IDEATION		
The following features should be rated with respect to the most severe type of ideation (i.e., 1-5 from above, with 1 being the least severe and 5 being the most severe). Ask about time he/she was feeling the most suicidal. Lifetime - ***Most Severe Ideation:*** _____ _____ *Type # (1-5)* *Description of Ideation* Recent - ***Most Severe Ideation:*** _____ _____ *Type # (1-5)* *Description of Ideation*	Most Severe	Most Severe
Frequency ***How many times have you had these thoughts?*** (1) Less than once a week (2) Once a week (3) 2-5 times in week (4) Daily or almost daily (5) Many times each day		
Duration ***When you have the thoughts how long do they last?*** (1) Fleeting - few seconds or minutes (2) Less than 1 hour/some of the time (3) 1-4 hours/a lot of time (4) 4-8 hours/most of day (5) More than 8 hours/persistent or continuous		
Controllability ***Could/can you stop thinking about killing yourself or wanting to die if you want to?*** (1) Easily able to control thoughts (2) Can control thoughts with little difficulty (3) Can control thoughts with some difficulty (4) Can control thoughts with a lot of difficulty (5) Unable to control thoughts (0) Does not attempt to control thoughts		
Deterrents ***Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?*** (1) Deterrents definitely stopped you from attempting suicide you (2) Deterrents probably stopped you (3) Uncertain that deterrents stopped you (4) Deterrents most likely did not stop you (5) Deterrents definitely did not stop you (0) Does not apply		
Reasons for Ideation ***What sort of reasons did you have for thinking about wanting to die or killing yourself? Was it to end the pain or stop the way you were feeling (in other words you couldn't go on living with this pain or how you were feeling) or was it to get attention, revenge or a reaction from others? Or both?*** (1) Completely to get attention, revenge or a reaction from others couldn't go on (2) Mostly to get attention, revenge or a reaction from others were feeling) (3) Equally to get attention, revenge or a reaction from others (you couldn't go on and to end/stop the pain were feeling) (4) Mostly to end or stop the pain (you living with the pain or how you (5) Completely to end or stop the pain living with the pain or how you (0) Does not apply		

COLUMBIA-SUICIDE SEVERITY RATING SCALE (C-SSRS)
Posner, Brent, Lucas, Gould, Stanley, Brown, Fisher, Zelazny, Burke, Oquendo, & Mann

RISK ASSESSMENT (Use if 13+)

Client Name:_____ C-SSRS

Client #: _____

FAMILY INSIGHT, P.C.
Enhancing the well-being of individuals and families℠

Client Name:_____ Lauris #: _____
Date safety plan created:___/___/___Date reviewed or updated:____/____/____

Community Based Safety Plan

Step 1: Warning Signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:
1._____
2._____

Step 2: Internal coping strategies- Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):
1._____
2._____

Step 3: People and social settings that provide distractions:
1. Name:_____Phone_____
2. Name:_____Phone_____

Step 4: People whom I can ask for help:
1. Name:_____Phone_____
2. Name:_____ Phone_____

Step 5: Professionals or agencies I can contact during a crisis:
1. Clinician Name:_____Phone: _____
2. Clinician Name:_____Phone: _____
3. Family Insight Local Crisis Phone (day): _____
4. Family Insight After-Hours Crisis Phone: _____
5. Local City/County CSB Emergency Services: _____
4. Suicide Prevention Lifeline Phone: 1-800-273-8255

Step 6: Making the environment safe:
1._____
2._____

One thing that is most important to me to help prevent my harmful behaviors to myself or others is: _____

Client Signature:_____Date:_____

Staff Signature:_____Date: _____

Guardian Signature:_____Date: _____

CREATING THE FAMILY SAFETY PLAN

The family safety plan is a document, created by the family, the children's safety network and child protection services, that describes in detail what the family and safety network will do, on a day--- to---da basis, to make sure that the children are safe and will remain safe, in the care of the family. The family safety plan also includes the details of how everyone will know that the family safety is working, an what will happen if there are problems with the family safety plan.

This Safety Planning Framework has been created to help the family, the safety network and the professionals work together to develop the family safety plan. Everyone works through this Safety Planning Framework together to decide what needs to be included in the family safety plan.

- The danger statements and the safety goals that have been developed with the family are written on the front page. These danger statements and safety goals provide direction so that everyone knov what the family safety plan needs to cover.
- The 'safety goal' pages are used to create the family safety rules or guidelines for each of the safety goals, with one page for each safety goal.
- The 'putting the plan into action' page is used to think about how the family safety plan will be presented to the children, how the family will show everyone that the safety plan is working, what everyo will do if there are problems, and how the family safety plan might need to be changed as the children get older or the family's circumstances change.
- The final page is used to take all of the safety rules and guidelines from the previous pages and write these in language that the children can understand. If the children are old enough, they will then dra pictures for each of the family safety rules to help them understand the family safety plan.

DANGER STATEMENTS *(These danger statements describe what everyone is worried might happen to the children in the parents' care if there is not an effective family safety plan in place. These danger statements need to be addressed by the safety goals and then by the family safety plan).*	**SAFETY GOALS** *(These safety goals are statements of WHAT the parents need to be doing in their care of the children to ensure that the dangers do not happen. The detailed safety plan is then a description of HOW the family will achieve these safety goals on a day-- to-- day basis).*

SAFETY GOAL: *(Write the safety goal below. Use one page for each safety goal)*

IMPORTANT SITUATIONS/ TIMES OF THE DAY/WEEK: What are the particular worrying circumstances or situations (identified in the danger statements) and the important times during the day and the week that the family safety plan needs to cover for this safety goal?

NON-- NEGOTIABLES: Here are the non---negotiables for this safety goal that the child protection agency has said have to be included in the safety plan.

GUIDING QUESTIONS: These questions have been provided by the child protection agency to help us think about all the areas that need to be covered for this safety goal.

1. SAFETY AND PROTECTION ALREADY HAPPENING: What are the parents/caregivers **already doing** or what were they **doing in the past** that will help to meet this safety goal? *(Get everyone's views).*

0 1

Scale: *On a scale of 0 -- 10, where 10 is what the parents are already doing is enough to meet this safety goal all of the time and 0 is that they have not yet been able to put anything in to place that will help to meet the safety goal, where are you on the scale?*

2. FUTURE SAFETY AND PROTECTION: What else could the parents/caregivers do that will help to meet this safety goal? *(Brainstorm everyone's ideas).* Continue until everyone is at a 10 (enough to meet safety goal).

0 1

Scale: *On a scale of 0 -- 10, where 10 is these safety ideas are enough to meet the safety goal all of the time and 0 is these ideas don't meet the safety goal at all, where ar on the scale? What else would you need to see the parents doing to move to a 10?*

SAFETY GOAL: *(Write the safety goal below. Use one page for each safety goal)*

IMPORTANT SITUATIONS/ TIMES OF THE DAY/WEEK: What are the particular worrying circumstances or situations (identified in the danger statements) and the important times during the day and the week that the family safety plan needs to cover for this safety goal?

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PUTTING THE SAFETY PLAN INTO ACTION

A. CHECKING WHETHER THE SAFETY PLAN IS WORKING

How will the parents/family show everyone that they are following the safety plan and that it is working?

Who will check in with the children and the parents to make sure that the plan is working? How often will this need to happen? In the beginning? Over the long term?

How often will everyone meet to talk together about how the safety plan is working? In the beginning? Over the long term?

When CPS withdraws, who will organise these meetings? How often will these meetings be held?

Write this information in language that the children can understand and include this in the safety plan.

B. WHAT WILL EVERYONE DO IF THERE ARE PROBLEMS WITH THE SAFETY PLAN

If the children are feeling worried or scared, how can they let people know?

What will family members and safety network members do if the children tell them that they are worri if they see a problem with the safety plan and/or are concerned about the children's safety?

What will CPS do if they are worried about the children's safety or they see a problem with the safety pl

What will the family and the safety network do if someone leaves the safety network?

Write this information in language that the children can understand and include this in the safety

C. PRESENTING THE SAFETY PLAN TO THE CHILDREN

Who will read the safety plan to the children and help them do pictures for each rule? When will this happen and who needs to be there when this happens?

Who will make copies of the safety plan (with children's drawings) and make sure everyone gets a copy?

Where will the family copy of the safety plan be kept (so that it is visible to everyone who needs to see it)?

How often in the future will the safety plan be read to the children? Who will make sure this happens?

Write this information in language that the children can understand and include this in the safety plan.

D. MAKING CHANGES TO THE SAFETY PLAN OVER TIME

As the children get older, what changes might be necessary to the safety plan?

How will this happen? Who will be part of changing the safety plan?

Who will get a copy of the new safety plan?

What if other circumstances change in the family?

Write this information in language that the children can understand and include this in the safet

WRITING THE FINAL SAFETY PLAN

WRITE THESE ACTIONS AND IDEAS AS SAFETY RULES FOR THE CHILDREN

The safety ideas and actions from all of the previous pages (safety goal pages and 'putting the safety plan into action' pages) are the basis for the family safety plan. Write these ideas and actions as family safety rules for the children, in language that the children will understand.

LOCAL COMMUNITY RESOURCES

cassie.purtlebaugh@dbhds.virginia.gov

Ann Pascoe |
804.297.1503

Jennifer Kovack |
804.248.8043
jennifer.kovack@dbhds.virginia.gov

Sharae Henderson | 804.524.7479

Reginald Daye
757.253.7061

Community Services Boards/ Mental Health Centers

The point of entry into the publicly funded system of services for mental health, intellectual disability, and substance abuse. CSBs provide pre-admission screening services 24-hours per day, 7 days per week.

Alexandria
City: Alexandria
720 N. Asaph Street, 4th Fl
Alexandria, VA 22314-1941
Crisis: (703) 746-3401
Main: (703) 746-3400
Fax: (703) 838-5062
https://www.alexandriava.gov/DCHS

Alleghany Highlands
City: Covington
County: Allegheny
601 Main Street
Clifton Forge, VA 24422
Days: (540) 965-2100
Crisis: (540) 965-6537
Emergency Services (After 5pm): 1-800-446-0128
Main: (540) 965-2135
Fax: (540) 965-6371
http://www.ahcsb.org

Crossroads Community Service Board
Counties: Amelia, Buckingham, Charlotte, Cumberland, Lunenburg, Nottoway, Prince Edward
P.O. Drawer 248
Farmville, VA 23901-0248
Crisis: 1-800-548-1688
Main: (434) 392-7049
Fax: (434) 392-5789
http://www.crossroadscsb.org

Cumberland Mountain
Counties: Buchanan, Russell, Tazewell
P.O. Box 810
Cedar Bluff, VA 24609-0810
Crisis: (276) 964-6702
Crisis After Hours: (800) 286-0586
Main: (276) 964-6702 or 964-6703
Fax: (276) 964-5669
http://www.cmcsb.com

Danville-Pittsylvania
City: Danville
County: Pittsylvania
245 Hairston Street
Danville, VA 24540
Crisis: 1-877-793-4922 (434) 793-4922
Main: (434) 799-0456
Fax: (434) 799-3100
http://www.dpcs.org

Dickenson County
County: Dickenson
P.O. Box 309
Clintwood, VA 24228
Crisis: (276) 926-1650
Main: (276) 926-1682
Fax: (276) 926-9179
http://www.dcbhs.com

Henrico Area Counties:
Charles City, Henrico, New Kent
10299 Woodman Road
Glen Allen, VA 23060
Crisis: (804) 727-8484
Main: (804) 727-8500
Fax: (804) 727-8580
http://henrico.us/mhds/

Highlands City: Bristol
County of Washington
Highlands Community
Counseling Center
802 Hillman Highway
Abingdon, VA 24216
Crisis: (276) 645-7400 Central
Dispatch – Bristol
(276) 676-6277 Central
Dispatch – Washington County
After Hours: 1-866-589-0269
Main: (276) 525-1550
Toll Free: 1-855-426-5263
Fax: (276) 628-3871
http://www.highlandscsb.org

Loudoun County
County: Loudoun
906 Trailview Blvd SE
Leesburg, VA 20176
Crisis: (703) 777-0320
Main: (703) 777-0378
Fax: (703) 777-0170
https://www.loudoun.gov/mhsads

New River City: Radford
Counties: Floyd, Giles,
Montgomery, Pulaski
700 University City Blvd.
Blacksburg, VA 24060
Crisis: (540) 961-8400
Main: (540) 961-8300
Fax: (540) 961-8469
http://www.nrvcs.org

Portsmouth DBHS
City: Portsmouth
1811 King Street
Portsmouth, VA 23704
Crisis: (757) 393-8990
Main: (757) 393-8618
Fax: (757) 393-5184
http://www.portsmouthva.gov/149/
Behavioral-Healthcare

Prince William County
Cities: Manassas, Manassas Park
County: Price William
8033 Ashton Avenue
Suite 103
Manassas, VA 20109
Services and Emergency,
Manassas: 703-792-7800
Services and Emergency,
Woodbridge 703-792-4900
Fax: (703) 792-7817
http://www.pwcgov.org/csb

Rappahannock Area
City: Fredericksburg
Counties: Caroline, King
George, Spotsylvania, Stafford
600 Jackson Street
Fredericksburg, VA 22401
Crisis:
Fredericksburg, Spotsylvania
County & Stafford County:
(540) 373-6876
Caroline County:
(804) 633-4148
King George County:
(540) 775-5064
Main: (540) 373-3223
Fax: (540) 371-3753
https://rappahannockareacsb.org