Behavioral Health Department
Alameda County Health

Mental Health Assessment

Adult Residential

INSTRUCTIONS: This template meets Medi-Cal requirements for documentation of initial mental health assessments and updates for services provided in an outpatient or clinic setting. New Assessments: All sections of this form must be completed. Assessment Updates: Please indicate "Update" and the date when adding updated information. For additional details regarding Medi-Cal documentation requirements, see Documentation Guide on the CalMHSA website at: CalMHSA

☐ Initial Assessment or ☐ Update

Episode Opening Date:		Medical Record #:		RU #:	

Provider Information			
Provider's Full Name:		Title and Credentials:	
Address:		Phone:	

Client Information					
Last Name (include Suffix):		First Name:			
Middle Name:		Date of Birth:		Age:	
Preferred Last Name:		Preferred First Name:			
Preferred Language:					
Sex Assigned at birth:	☐ Male ☐ Female ☐ Intersex ☐ Other:				
Gender Identity:	☐Male ☐Female ☐Intersex ☐Gender Queer ☐Gender non-conforming ☐Prefer not to answer ☐Male to Female/Transgender Female/Trans Woman ☐Female to Male/Transgender Male/Trans Man ☐ Unknown ☐Other Additional Gender Category:				
Sexual Orientation:	☐Unknown ☐Heterosexual/Straight ☐Bisexual ☐Gay ☐Lesbian ☐Queer ☐Questioning ☐Other Additional Sexual Orientation:				

Emergency Contact			
Full Name:		Relationship:	
Address:		Phone:	
☐ Release for Emergency Contact obtained for the following time period:			

Allergies

☐Yes ☐No Allergies were reported. If yes, provide details:				
Source of Information: (Check All that apply)	☐Client	☐Family/Guardian	☐Hospital	☐Other:

Service Details

Instructions: Enter time as minutes. Service Time, Documentation, and Travel time should add up to Total Time.

Service Time is the time SmartCare will use to determine the number of units to claim Medi-Cal for the HCPC or CPT code.

Service Start Time:				Duration:		Total Time:	
Doc. Time:		Travel Time:		Location:		Mode of Delivery:	
Primary Procedure Code:						Interactive Complexity:	☐ Yes ☐ No
Add-on Code 1:						Code Time:	
Add-on Code 2:						Code Time:	
Service was provided in:	English					Was an interpreter required? ☐ Yes ☐ No	
Interpreter Name/Staff ID:						# of minutes of interpretation:	

DOMAIN 1: PRESENTING PROBLEM/ CHIEF COMPLAINT

Presenting Problem (Current and Historical) - The person's and collateral sources' descriptions of problem(s), history of the problem(s) and impact on the person in care. When possible, include duration, severity, context and cultural understanding of the chief complaint and its impact.

Impairments in Functioning: Functioning should be considered in a variety of settings, including at home, in the community, at school, at work and with friends or family.

Impairment Area	None	Mild	Mod	Severe	Impairment Area	None	Mild	Mod	Severe
Family Relations	☐	☐	☐	☐	Substance Abuse	☐	☐	☐	☐
School Performance/ Employment	☐	☐	☐	☐	Activities of Daily Living	☐	☐	☐	☐
Social/Peer Relations	☐	☐	☐	☐	Physical Health	☐	☐	☐	☐
Food/Shelter	☐	☐	☐	☐	Self-Care	☐	☐	☐	☐

Episodes of Decompensation	☐	☐	☐	☐	☐ Other (Describe):
Details of Impairments noted above:					

Current Mental Status Exam (MSE): Mental status at the time of assessment (See APPENDIX A for Early Childhood MSE, 0-5 years old)				
Appearance/Grooming:	☐ Unremarkable	☐ Remarkable for:		
Behavior/Relatedness:	☐ Unremarkable ☐ Impulsive	☐ Motor Agitated ☐ Motor Retarded	☐ Inattentive ☐ Avoidant ☐ Hostile	☐ Suspicious/ Guarded ☐ Other
Speech:	☐ Unremarkable	☐ Remarkable for:		
Mood/Affect:	☐ Unremarkable ☐ Labile	☐ Depressed ☐ Irritable/Angry	☐ Elated/Expansive ☐ Anxious	☐ Other
Thought Processes:	☐ Unremarkable ☐ Odd/Idiosyncratic ☐ Tangential	☐ Concrete ☐ Obsessive ☐ Blocking ☐ Distorted	☐ Paucity of Content ☐ Circumstantial ☐ Loosening of Association	☐ Disorganized ☐ Flight of Ideas ☐ Racing Thoughts ☐ A
Thought Content:	☐ Unremarkable	☐ Hallucinations	☐ Delusions ☐ Ideas of Reference	☐ Other
Perceptual Content:	☐ Unremarkable ☐ Flashbacks ☐ Derealization	☐ Hallucinations ☐ Dissociation	☐ Homicidal Ideation ☐ Depersonalization	☐ Paranoid ☐ Other
Fund of Knowledge:	☐ Unremarkable	Remarkable for:		
Orientation:	☐ Unremarkable	Remarkable for:		
Memory:	☐ Unremarkable	Impaired:		
Intellect:	☐ Unremarkable	Remarkable for:		
Insight/Judgment:	☐ Unremarkable	Remarkable for:		
Describe Mental Status Exam abnormal/impaired findings:				

DOMAIN 2: TRAUMA
Trauma Exposure(s) – A brief description of traumatic event(s) underlying or contributing to the person's symptoms. It is not necessary to document the details of the trauma in depth.
Trauma Reactions – The person's response to the traumatic event and it's impact on the person's behavioral health condition.

Trauma Screening – Results of any trauma screening tools [e.g., Adverse Childhood Experiences (ACEs)], indicating elevated risk for developing a behavioral health condition.

Systems Involvement – The person's experience with homelessness, justice involvement, or involvement in the child welfare system.

DOMAIN 3:
BEHAVIORAL HEALTH HISTORY

Mental Health History – Review of acute or chronic conditions not earlier described, including mental health conditions previously diagnosed or suspected. Current and past treatment and the person's ability and willingness to participate.

Substance Use/Abuse – Review of past/present use of substances, including substance use conditions previously diagnosed or suspected. Current and past treatment and the person's ability and willingness to participate.
For youth, also assess for substance exposure.

☐ No current or past substance abuse issues were identified. SKIP TO DOMAIN 4

Substance Name	Past	Current	Frequency	Method	Last Used
	☐	☐			
	☐	☐			
	☐	☐			
	☐	☐			

DOMAIN 4: MEDICAL HISTORY AND MEDICATIONS		
Significant Weight Changes in the last 6 months:	☐ Yes ☐ No	If yes, explain:

Physical Health Conditions – Relevant current and past medical conditions, including current and past treatment and the person's ability and willingness to participate in treatment.

Developmental History – Prenatal and perinatal events and relevant or significant developmental history, if known and available (primarily for individuals 21 years old or younger)

Medications –Include psychotropic and non-psychotropic (physical health) medications.

Current or Past	Reason for Use	Medication Name	Dosage	Efficacy	Start Date	End Date	Prescriber's Name
☐ Current ☐ Past							
☐ Current ☐ Past							
☐ Current ☐ Past							
☐ Current ☐ Past							
☐ Current ☐ Past							

Other Medication Notes:

Date of Last Physical Exam:		Date of Last Dental Exam:	

Name and Phone Number of Medical and Dental Providers (if known):

DOMAIN 5: PSYCHOSOCIAL FACTORS

Family - Family history, current family involvement, significant life events within family (e.g., loss, divorce, births)

Social and Life Circumstances – Current living situation, daily activities, social supports, legal/justice involvement, military history, community engagement.

Cultural Considerations – Cultural factors, linguistic factors, gender identity and sexual orientation, race, spirituality and/or religious beliefs, values, and practices.

This section ONLY required for YOUTH under 18 years old (Otherwise skip to Domain 6)

Living Situation

☐ Biological/Adoptive Family	☐ Kinship Family	☐ Resource/Foster Family	☐ Other:

First Name of Others in Home (Children and Adults)	Age	Relationship

Education

☐ Current School:		
Grade:	Contact/Teacher Phone #:	Active IEP/Special Ed Assessment/Services: ☐ LD ☐ DD/ID ☐ SED ☐ 504 Plan

This section ONLY required for individuals under 21 years old (Otherwise skip to Domain 6)

THERAPEUTIC FOSTER CARE (TFC), INTENSIVE CARE COORDINATION (ICC), and INTENSIVE HOME-BASED SERVICES (IHBS)

All Beneficiaries under 21 years of age must be assessed to determine if they qualify and need Therapeutic Foster Care (TFC), Intensive Care Coordination (ICC), and Intensive Home-Based Services (IHBS). SEE APPENDIX B

Check to indicate that client has been assessed for these services: ☐ TFC/ICC/IHBS

Check to indicate that a referral is made to these services: ☐ TFC/ICC/IHBS

DOMAIN 6: STRENGTHS, RISKS AND PROTECTIVE FACTORS
Strengths and Protective Factors – Personal or family motivations, hobbies and interests, positive coping skills, support systems including faith-based supports, children, etc.
Risk Factors and Behaviors – Current and history of risk including family history of suicide/homicide, triggers, context for risk behaviors (e.g., loneliness, gang affiliations, psychosis, drug use/abuse). May include specific risk screening/ assessment tools (e.g., Columbia Suicide Severity Rating Scale).
Safety Planning –Detailed, individualized safety plan to be used should risk behaviors arise. A comprehensive written safety plan is required if risk has been identified in the last 90 days. ☐ Risk assessed. Safety Plan is not needed.
Adult Daily Living (ADL)Assessment
Meal Planning Assessment:
Budgeting Assessment:
Shopping Assessment:

Domain 7: CLINICAL SUMMARY, TREATMENT RECOMMENDATIONS, LEVEL OF CARE DETERMINATION
Clinical Impressions – Clinical formulation of the case based on information collected, including s**ummary of clinical symptoms supporting diagnosis** ☐ Meets Access Criteria ☐ Meets Medical Necessity Criteria
Diagnostic Impression – Current psychiatric diagnoses, including rule-outs, provisional or unspecified, as well as known medical diagnosis.

CURRENT DSM Diagnosis			
DSM Descriptor	ICD-10	ICD-10 Descriptor	Primary or Rule Out
			☐ Primary ☐ Rule Out
			☐ Primary ☐ Rule Out
			☐ Primary ☐ Rule Out
			☐ Primary ☐ Rule Out
Diagnosis Established by Name:		License Type:	
Registered/Waivered: ☐ Yes ☐ No	Name and License Type of Clinician Co-Signing:		

Treatment Recommendations –Detailed and specific interventions and services recommended based on clinical impression and overall goals for care.

Referrals Provided		
☐ Substance Use Disorder Services	☐ Primary Care Physician (Refer if last seen more than 1 year ago).	☐ Specialty Medical Services
☐ Dental	☐ TFC ☐ ICC ☐ IHBS	☐ Other
Link to ACBH SUD Resource Page: BHCS Providers Website (acbhcs.org)		

Referral Details:			
Forms Signed or Needed	Signed	Needed	Expiration Date
Informing Materials (Needed annually)	☐	☐	
Release of Information for Emergency Contact- Name:	☐	☐	
Release of Information for Other- Name:	☐	☐	
Other:			

Signatures			
Print Name of Service Provider		Title and Credentials	
Signature		Date	
Print Name of Supervisor (if needed)		Title and Credentials	
Signature		Date	

Appendix A

Early Childhood Mental Status Exam (ages 0-5)

Current Mental Status – Use for Early Childhood (Ages 0-5)				
Appearance:	☐ Disheveled ☐ Well-groomed	☐ Atypical features ☐ Other	☐ Small for age	☐ Visible marks/bruises
Reactions:	☐ Explores ☐ Freezes ☐ Cries	☐ Frustrates easily ☐ Apathetic ☐ Withdrawn	☐ Aggressive ☐ Tantrums easily	☐ Within Normal Range (WNR) ☐ Other
Ability to Regulate:	☐ Quiet Alert ☐ Active Alert ☐ Distressed	☐ Seeks excessive stimulation ☐ Smooth transitions ☐ Abrupt transitions	☐ Able to soothe self ☐ Able to be soothed	☐ Hyper-responsive ☐ Hypo-responsive ☐ WN ☐ Other
Mood:	☐ Depressed ☐ Anxious	☐ Irritable	☐ Angry	☐ WNR
Affect:	☐ Flat ☐ Restricted	☐ Fearful	☐ Labile	☐ WNR
Cognition:	☐ Precocious	☐ Developmental Delay	☐ Other	☐ WNR
Thought:	☐ Nightmares ☐ Dissociation	☐ Fear of Separation	☐ Specific fears	☐ WNR ☐ Other
Speech/Language:	☐ Expressive language concerns	☐ Receptive language concerns	☐ Echolalia	☐ WNR ☐ Other
Motor Activity:	☐ Calm ☐ Agitated	☐ Decreased motor activity	☐ Unusual gait ☐ Hyperactive	☐ Tremors ☐ WNL
Repetitive Behaviors:	☐ Head banging	☐ Hand flapping	☐ Rocking	☐ Other
Unusual Behaviors:	☐ Sexual behavior ☐ Self-harming ☐ Aggressive	☐ Obsessive/ Compulsive	☐ Regressive behavior ☐ Indiscriminate attachment	☐ Other
Describe Mental Status Exam abnormal/impaired findings:				

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Appendix B

Intensive Service Needs Assessment: Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), Therapeutic Foster Care (TFC)

All beneficiaries with full-scope Medi-Cal under 21 years old must be assessed to determine if they qualify for and need ICC, IHBS and/or TFC and referred to those services.

Links to Referral Forms in English are provided below. For Referral Forms in Spanish, use this website: Child & Youth Services – Alameda County Behavioral Health (acbhcs.org)

Based upon the clinical assessment, indicate if any of the services below are needed:

Service Type	Status	Required Next Steps
Intensive Care Coordination (ICC) is needed and cannot be adequately provided under standard mental health case management services.	☐ Yes ☐ No ☐ Already Connected	If checked, referral required ICC Referral Form
Intensive Home-Based Services (IHBS) are needed to assist the child/youth in building the skills necessary to successfully function at home and in the community and to assist their family in developing the skills needed to support the child/youth in achieving this goal. These services cannot be adequately provided under standard mental health case management services.	☐ Yes ☐ No ☐ Already Connected	If checked, contact the ICC provider listed on the face sheet to recommend IHBS at next Child and Family Team Meeting (CFT)
Therapeutic Foster Care (TFC) services are needed to address the child/youth's severe emotional issues by providing intensive therapeutic and behavior management services in an in-home, family-based care setting.	☐ Yes ☐ No ☐ Already Connected	If checked, contact the Child and Family Team facilitator (from ICC, Child Welfare, or Probation) to make the recommendation for TFC