IN-HOME BEHAVIORAL INTERVENTION SERVICE ASSESSMENT TOOL

THE HSC HEALTH CARE SYSTEM
Health Services for Children with Special Needs, Inc.

Part I: BEHAVIORAL HEALTH NEEDS ASSESSMENT

This assessment is to be completed face-to-face with the client within 5 days of receiving a referral.

DATE:	**MEMBER NAME:**
Part I: Background Information and Observations:	
Briefly describe presenting problems requiring home services (from Provider Referral form):	
Briefly describe presenting problems as explained by care provider and enrollee:	
Family history and evaluation of current family status, including legal custody status (Involvement, if any with CFSA, DYRS or DDS)	
Health (If physical health is a contributing problem/issue, provide details. Otherwise write n/a)	
Observations/Mental Status of Enrollee	

Part II: Habilitation/Rehabilitation Assessment

Age appropriate self-help skills (personal hygiene, grooming)

Strengths:
Barriers:
Needs:

Social, Peer, Family and Teacher Interaction Skills

Strengths:
Barriers:
Needs:

Academic Achievement and/or Vocational

Strengths:
Barriers:
Needs:

Semi-independent Living Skills

Strengths:
Barriers:
Needs:

Family functioning (communication, relationships, food preparation, nutrition, and dietary planning, safety, drug use by family members)

Strengths:
Barriers:
Needs:

Participation in Psychiatric Treatment

Strengths:
Barriers:
Needs:

What are the current resources and support system?

Strengths:
Barriers:
Needs:

Self-Administration and management of medication (understanding of disorder and need for medication)

Strengths:
Barriers:
Needs:

Are there any legal issues? If yes, what is the status?

List other factors that may pose a challenge to the individual's successful habilitation/rehabilitation

Is there a history of substance abuse or involvement?

Leisure time activity

Strengths:
Barriers:
Needs:

Issues that need immediate attention and are a major concern

Comments

Part III: MEDICAL NECESSITY CRITERIA APPLICATION

Member:

Clinical Indications (within last week): *BOTH*

1. **Current DSM-V-TR diagnosis, *One***
Current Diagnosis:

Potential for Improvement? ☐ Yes ☐ No

2. **Symptoms / Behavior, *One***

☐ Aggression: verbal, physical, injurious or destructive behavior such as biting, kicking, punching, bullying, cruelty to animals; destruction of property, threatening fire-setting; self-injurious behavior such as cutting skin, pulling out hair, burning, branding or rubbing skin to produce sores or scars

☐ Extreme Impulsivity: includes daredevil behavior that involves risk-taking that could be a danger to self

☐ Overt Agitation: child having problems managing the following: vocalizations, upper extremity movements, lower extremities; frustration tolerance
Non-compliant behavior: unwilling to follow the simplest of rules; requires constant re-direction; requires constant supervision

☐ Emotional Instability: acting on delusions, angry outbursts with increasing frequency and intensity, mood liability, isolates self in room

Social Risks (within last month): *BOTH*

1. **Treatment History, *One***

☐ Discharge/Transfer from a more restrictive level of care such as a psychiatric hospital or PRTF within the week with a significant risk for decompensation without behavioral home care services.

☐ There is repeated failure to adhere to recommended outpatient ITP despite motivational support from the provider, peer support and other community support services, and behavioral home care services are required to facilitate adherence.

☐ Over the last 6 months, the member has demonstrated a pattern of hospitalization, emergency room or crisis team visits in spite of compliance with provider treatment, peer support and other community support services, and there is an imminent risk of out-of-home placement without Behavioral home care services

- ☐ The member is homebound secondary to either a medical condition or severe psychiatric or developmental disability.
- ☐ The member's current condition or circumstances temporarily prevent an office-based or facility- based treatment.
- ☐ In-home services are needed to assess the member's strengths, likely causes, and/or identify signs of deterioration.

2. **Support System, *All***

- ☐ Parent/Caregiver available (in the home at the time services are delivered)
- ☐ Parent/caregiver unable to manage intensity of symptoms
- ☐ Parent/caregiver willing to participate in home-based and outpatient treatment services

Part IV: Does the member meet medical necessity? ☐ **Yes** ☐ **No (If No, explain below)**

If yes, provide recommended days and number of hours per week of behavioral intervention below (For example: M-F, 2 hours per day or M, W and Saturdays, 2 hours per day). Note that over 10 hours per week of treatment hours requires Physician Reviewer approval.

Independent Licensed Behavioral Health Professional **Date**