CAPE ATLANTIC I.N.K.
Integrated Network for Kids
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Executive Director

BioPsychoSocial (BPS) Requirements

This document summarizes important requirements and expectations for the role and responsibilities of the needs BPS assessor. Service recommendations need to be consistent with youth's safety needs. As an assessor, you are expected to address immediate safety needs such as making referrals to screening, ER and DCP&P at the time of assessment. (i.e.: danger to self or others, child abuse/neglect, active substance use/withdrawal)

Instructions for Completion

- Assessor should understand the CMO criteria and Children's System of Care services (available on www.performcarenj.org website under 'providers') before making service recommendations.
- Ensure that the information submitted is specific to the youth and family being assessed.
- Diagnosis ICD-10 should be justified throughout the assessment.

BPS Provider Requirements

- Clinical licensure (such as LCSW, LPC, LMFT, and/or LCADC) is required to complete the H0018TJU1 assessment. It is *not* acceptable for the assessment to be completed by a clinical intern or a lower level licensure under the supervision of a clinically licensed independent provider.
- BPS assessments shall be conducted only by IIC providers who have been certified by the Children's System of Care (CSOC) as possessing the capacity to complete IMDS Needs Assessments with a reliability score of .7 or above Individual assessors must be recertified annually by accessing the above website.
- It is the *independent provider's* responsibility to ensure compliance with certification and re-certification.

Timeframes

- Providers must outreach to the family to schedule appointment within 3 days of authorization start date.
- If authorized Provider is unable to make contact with the family, Cape Atlantic I.N.K.'s Care Manager (the referent) must be contacted to assist the Provider in connecting with the family or to "turn back" the referral within 3 days of the authorization start date.
- Completed assessment must be submitted to Cape Atlantic I.N.K. via fax, 10 days of authorization start date with Cape Atlantic I.N.K.'s billing invoice.

Consent

- Assessment must be **completed face-to-face** with youth (and legal guardian if youth is under the age of 18) in a clinically appropriate, non-office-based setting.
- Interviews via phone, internet, Skype, etc. are *unacceptable*.
- If youth is 18 or older, please ensure that youth/young adult has consented for services.

Collateral Contacts (*if appropriate*) and Recommendations

- All assessments must include a ROI allowing assessor to make collateral contacts.
- Collateral contacts must be made and documented (School, DCP&P, Probation, etc.)
- Ensure that services/recommendations are clinically justified throughout the body of the assessment.
- Please advise the family that they will be contacted by the Care Manager regarding the outcomes of the assessment.
- **Note** that assessor's recommendations are not a guarantee of authorized services.

Clinical Summary

Date:	|Assessor Name:	|Credentials:
Provider Agency:		
Fax:	|Phone:	|Email address:
Mailing Address:		

Youth's Name:	|DOB:
Gender:	|Race/Ethnicity:

Parent/Legal Guardian's Name:		
Guardianship Status (i.e. DCP&P Custody or Guardianship):		
Address:		
City:	|State	|Zip Code:
Primary Phone:	|Secondary Phone:	
Youth's current address (if different from above):		
Primary Language spoken in the home:		

Care Manager: _____Contact Ph#: _____ Date of Referral:_____

Reason for Referral:

Involvement Current Status/Treatment and Youth System

Behavioral Health *(include: outpatient, intensive in-home, partial hospitalization/partial care program, out-of-home, inpatient hospitalization)*

Substance Use *(include type of substance, patter of use, age of onset, types of treatment: outpatient, intensive outpatient, partial hospitalization, short/long term residential, detoxification, inpatient hospitalization)*

Physical Health/Medical *(include active issues):*

Specialty Needs *(include fire setting or problematic sexual behavior):*

School *(include type of school placement, i.e. regular education, special education, in/out of district, home instruction*

DD Eligibility Status *(include describing any functional challenges or limitations)*

Contact information for DCP&P case worker and supervisors, if involved	
DCP&P Case worker:	**|Phone:**
DCP&P Supervisor	**|Phone:**

Current court orders? **Yes |☐** **No |☐**
Specify:

Current Presenting Behavioral Symptoms

Youth Behavioral/Emotional Needs *(please check any behaviors that are relevant to the treatment needs of the youth and/or exhibited in the last 30 days):*

☐	**Psychosis** (Hallucinations, delusional thoughts, bizarre, odd behaviors, speech, and thoughts)	☐	**Anxiety** (Social anxiety, generalized anxiety, panic symptoms)	☐	**Anger Control** (The youth's ability to manage their anger)
☐	**Impulsivity/Attention** (Challenges with impulse control)	☐	**Oppositional Behavior** (disrespectful, argumentative behaviors, difficulty with accepting rules from authority figures)	☐	**Conduct** (Antisocial behaviors including stealing, vandalism, cruelty to animals, assaultive behaviors)
☐	**Depression** (Irritable or depressed mood, isolative, withdrawn behaviors, thoughts of hopelessness, sleep and appetite changes, loss of motivation)	☐	**Exposure to Implicit Trauma** (Implicit trauma refers to experiences and historical events which may not result in specific memories or overt reactive behaviors, but may contribute to current behavioral/ emotional symptoms) ex. Adoption, loss of a family member	☐	**Exposure to Explicit Trauma** (Explicit trauma refers to traumatic experiences which directly correlate with post-traumatic emotional and behavioral symptoms) **ex**. Sexual molestation
☐	**Problematic Technology Use** (The impact of the technology use on the youth's daily functioning including their ability to maintain relationships, complete school work etc.)	☐	**Gambling** (Youth's involvement with all forms of gambling, legal and illegal)	☐	**Other** :

Please give a detailed description of all checked behaviors /symptoms include any current presenting symptoms and any history of these symptoms:

Youth Risk Behaviors *(please check any behaviors that are relevant to the treatment needs of the youth and/or exhibited in the last 30 days):*

☐	**Suicide Risk** (This includes suicidal thoughts, plans, and behaviors	☐	**Danger to Others** (This includes actual and threatened violence)
☐	**Flight Risk** (This includes any planned or unplanned wandering, impulsive running; consider age of the youth, frequency, duration o f escape episodes, timing, and context)	☐	**Problematic Sexual Behaviors** (This includes any sexually aggressive behavior where an older youth takes advantage of a younger youth) (Specialty Evaluation may be indicated if youth is being referred for OOH treatment)
☐	**Other Self Harm:** (Other high risk behaviors which impacts personal safety and increases the risk of personal injury that is not considered suicidal behavior or intentional self-injurious behavior)	☐	**Substance Use:** (This refers to any use of tobacco, alcohol, or illegal drugs) (Specialty Evaluation may be indicated if youth is being referred for OOH treatment)
☐	**Self-Injurious Behaviors:** (Any intentional self-harming behaviors that does not have suicidal intent	☐	**Judgment**: (This refers to the youth's decision-making ability
☐	**Legal/ Juvenile Justice:** (This includes any behavior which a youth exhibits that results in involvement with the legal system)	☐	**Fire Setting:** (This refers to when youth intentionally start fires) (Specialty Evaluation may be indicated if youth is being referred for OOH treatment)
☐	**Other:**		

Detailed description of all checked risk behaviors; please include any current presenting risk behaviors and any history of these risk behaviors:

Youth Strengths (*please check any issues that are relevant to the treatment needs of the youth and/or exhibited in the last 30 days)*

☐	**Family Strengths** - Ability to support the youth's overall progress and development	☐	**Relationship Stability** - Stability of relationships with friends and family
☐	**Talents / Interests which the youth exhibits**	☐	**Community Involvement** - The quality of the youth's connection to their community
☐	**Youth's involvement with care and treatment planning**	☐	**Optimism** - Youth's personal sense of optimism
☐	**Self-Expression -** Youth's ability to express his/her thoughts and feelings	☐	**Spirituality** - Youth's involvement with spiritual or religious beliefs and practices and activities
☐	**Wellness Behaviors** - Indicators that the youth exhibits health-promoting behaviors and makes good lifestyle choices	☐	**Resiliency** - The youth's innate ability to enjoy positive life experiences and manage negative life experiences
☐	**Other**:		

Detailed description of all checked strengths:

History of Treatment and Youth System Involvement

Provide detailed information for all applicable sections including start/end dates and name of provider/agency/facility - limit to the past 3 years

Behavioral Health *(include: outpatient, intensive in-home, partial hospitalization/partial care program, out-of-home, inpatient hospitalization)*

Substance Use *(include type of substance, patter of use, age of onset, types of treatment: outpatient, intensive outpatient, partial hospitalization, short/long term residential, detoxification, inpatient hospitalization)*

Physical Health/Medical *(include active issues):*

Specialty Needs *(include fire setting or problematic sexual behavior):*

School *(include type of school placement, i.e. regular education, special education, in/out of district, home instruction*

Juvenile Justice *(include case pending, FCIU, probation, detention, day program, Detention Alternative Program, incarceration, parole):*

<u>Current ICD-10 Behavioral Health Diagnoses</u> ***(****all required)*

Name of practitioner who diagnosed youth:	
Credentials:	**Date of diagnosis:**
List of diagnosis:	
Current Intellectual/Developmental disability diagnosis, if any:	
Most recent IQ:	
Current Prescription Medications: *(specify all - name dosage, frequency, start and end dates)*	

Clinical Summary/Formulation

Please describe in a brief statement what are the presenting clinical needs, the overall clinical impression and diagnosis, and recommended treatment plan or strategies including frequency, intensity, and duration of interventions):

Information Sources *(e.g. parents/caregiver, foster parents, group home worker, probation worker, CMO worker, teacher, etc.):*

Name	Relationship to Youth	Phone Number

Printed Name of Assessor:	
Signature of Assessor:	
Credential:	**Date:**