CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)

COMPREHENSIVE MULTISYSTEM ASSESSMENT

Template

Developed in Collaboration with the

A large number of individuals have collaborated in the development of the CANS-Comprehensive Along with the CANS versions for developmental disabilities, juvenile justice, and child welfare, this information integration tool is designed to support individual case planning and the planning and evaluation of service systems. The CANS-Comprehensive is an open domain tool for use in service delivery systems that address the mental health of children, adolescents and their families. The copyright is held by the Buddin Praed Foundation to ensure that it remains free to use. For specific permission to use please contact Melanie Lyons of the Foundation. For more information on the CANS-Comprehensive assessment tool contact:

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Registration

(required field)*

***Referring Party**: _____

***Geographic Area:** _____

***Is this a SWETP Referral?** ☐ **Yes** ☐ **No**

***Are Supplemental clinicals expected?** ☐ **Yes** ☐ **No**

Contact Name:** _____Phone:** _____

SW/Probation/Parole/Public Defender Name:** _____Phone:** _____

Program Supervisor Name:** _____Phone:** _____

SW/Probation/Parole/Public Defender Supervisor Name:** _____Phone:** _____

Behavioral Health Program Director Name:** _____Phone:** _____

AD Designee Who Approved Congregate Care request:** _____Phone:** _____

***Link Person #:** _____

***Link Case#:** _____

***Client Medicaid ID #:** _____

***Case #:** _____

Present Placement:** _____Court Ordered Placement?** ☐ **Yes** ☐ **No**

***Date of next Hearing:** _____

CSSD/Probation Information (0-250 characters)

_____

_____

_____

_____

Diagnosis*:*
(Documentation of primary behavioral condition is required. Provisional working condition and diagnosis should be documented if necessary. Documentation of secondary co-occurring behavioral conditions that impact or are a focus of treatment (mental health, substance use, personality, intellectual disability) is strongly recommended to support comprehensive care. Authorization (if applicable) does NOT guarantee payment of benefits for these services. Coverage is subject to all limits and exclusions outlined in the member's plan and/or summary plan description including covered diagnoses.)

1) ***Behavioral Diagnoses (*Primary is required)***

***Diagnosis Code:** _____ ***Description**_____

***Diagnostic Category:** _____

Diagnosis Code: _____ **Description**_____

Diagnostic Category: _____

2) ***Primary Medical Diagnoses *(Primary is required or indicate "None" or "Unknown")***

***Diagnosis Code:** _____ ***Description**_____

***Diagnostic Category:** _____

Diagnosis Code: _____ **Description**_____

Diagnostic Category: _____

***Social Elements Impacting Diagnoses (Required - Check all that apply)**

☐None ☐Educational problems ☐Financial problems ☐Housing problems (Not Homelessness)

☐Occupational problems ☐other psychosocial and environmental problems_____

☐Problems with access to health care services ☐Homelessness ☐Problems related to interaction with legal system / crime ☐Problems with primary support group ☐Problems related to social environment ☐Unknown

☐Medical Disabilities that impact diagnosis or must be accommodated for in treatment

3) **Functional Assessment *(Optional)***

☐CDC- HRQOL ☐CGAS ☐FAST ☐ GAF ☐OMFAQ ☐ SF12 ☐SF36 ☐ WHO DAS

☐OTHER _____ Assessment Score: _____

Diagnosis By: _____ Date of Diagnosis: _____

CANS: Member Demographics

***Type of CANS:** ☐ Initial ☐ Reassessment

***CANS Completion Date:** _____

***Date of this Assessment:** _____

***Clinical Information Contact Name** _____ **Phone:** _____

***Guardian Ad Litem:** _____

***Child's Attorney:** _____

***School Nexus:** _____

***Current DCF Status:** ☐ **CPS In-home** ☐ **DCF Committed** ☐ **Voluntary Service** ☐ **Voluntary Pending**
☐ **Family with Service Needs** ☐ **JJ Committed** ☐ **Dually Committed (CPS/JJ)**
☐ **OTC** ☐ **Delinquency Pending** ☐ **FWSN Pending** ☐ **FWSN** ☐ **Voluntary (age of majority)**
☐ **Non Committed** ☐ **Open Investigation** ☐ **Order of Temporary Custody** ☐ **Pending 136**
☐ **Probate** ☐ **Protective Supervision** ☐ **Termination of Parental Rights** ☐ **Unknown**
☐ **N/A** ☐ **Voluntary Services** ☐ **Voluntary Services Pending**

***Primary Language Spoken:** _____

***Member 12 years or younger?** ☐ **Yes** ☐ **No**

If Yes, Case Conference with Central Office Date: _____ **or** ☐ **N/A**

If Yes, Case Conference Recommendations (up to 250 characters)

_____

_____

_____

_____

_____

***Current Living Situation** *(see below)*:

☐ **Adult Justice System** ☐ **AWOL** ☐ **CCP** ☐ **CJTS** ☐ **Crisis Stab.** ☐ **Detention** ☐ **Foster Care** ☐ **GH**

☐ **Independent** ☐ **Hospital (Psych)** ☐ **OOS** ☐ **Parent** ☐ **PDC** ☐ **RTF (Psych)** ☐ **Relative** ☐ **RTC** ☐ **Riverview**

☐ **Shelter** ☐ **STAR** ☐ **TFH** ☐ **TH** ☐ **TLAP** ☐ **Other** _____

Facility Name, if appropriate: _____ **Facility Phone #:** _____

Facility Address: _____ **City** _____ **State** _____ **Zip** _____

Admission Date: _____

Current Living Situation *(see below)*:

☐ **Adult Justice System** ☐ **AWOL** ☐ **CCP** ☐ **CJTS** ☐ **Crisis Stab.** ☐ **Detention** ☐ **Foster Care** ☐ **GH**

☐ **Independent** ☐ **Hospital (Psych)** ☐ **OOS** ☐ **Parent** ☐ **PDC** ☐ **RTF (Psych)** ☐ **Relative** ☐ **RTC** ☐ **Riverview**

☐ **Shelter** ☐ **STAR** ☐ **TFH** ☐ **TH** ☐ **TLAP** ☐ **Other** _____

Facility Name, if appropriate: _____ **Facility Phone #:** _____

Facility Address: _____ **City** _____ **State** _____ **Zip** _____

Admission Date: _____

Current Living Situation:

Parent: Living with biological or adoptive parent(s)
Relative: Living with biological relative
Independent: Independent living
Shelter: Living in shelter with family
Crisis Stab: Crisis Stabilization Unit
FH: Foster Home
TFH: Therapeutic Foster Home
TH: Treatment Home
GH: Group Home (Supervised Apts, Supportive Living – DDD
SH: Safe Home
PDC: Permanency Diagnostic Center
TLAP: Transitional Living Program
RTC: Residential Treatment Center
CCP/HM: State run residential programs for children and adolescents
PRTF: Psychiatric Residential Treatment Facility
Hospital (Psych): In-patient psychiatric hospital
RVH: Riverview: State run inpatient psychiatric hospital
STAR: Short Term Treatment and Assessment Residential
Detention: Youth Detention Center
CJTS: Connecticut Juvenile Training School
Adult Justice System: York/Manson
AWOL: Absent with out leave -- elopement
UR: Living w/ unrelated person
Other: None of above situations
OOS: Out of State

CANS: LIFE DOMAIN FUNCTIONING

0=no evidence of problems 1=history, mild 2=moderate 3=severe N=Not Assessed
Please complete notes if "3" is selected

	0	1	2	3	N/A	
1) Family	☐	☐	☐	☐	☐	Notes: _____
2) Living Situation	☐	☐	☐	☐	☐	Notes: _____
3) Social Functioning	☐	☐	☐	☐	☐	Notes: _____
4) Recreational	☐	☐	☐	☐	☐	Notes: _____
5) Vocational	☐	☐	☐	☐	☐	Notes: _____
6) Legal	☐	☐	☐	☐	☐	Notes: _____

7) Physical ☐ ☐ ☐ ☐ ☐ Notes: _____

8) Developmental ☐ ☐ ☐ ☐ ☐ ***(Complete Developmental Needs Module below)***

DEVELOPMENTAL NEEDS (DD) MODULE

This module is intended to describe any needs that might involve services for Developmental Disabilities including services provided through the Department of Developmental Disabilities.

	0	1	2	3	N/A
1) Cognitive	☐	☐	☐	☐	
2) Communication	☐	☐	☐	☐	
3) Developmental	☐	☐	☐	☐	
4) Self Care/Daily Living	☐	☐	☐	☐	

Specify IQ: _____ (Check if Unknown) ☐ Unknown

Means of assessment: _____

Specify Developmental Diagnoses: _____

Does the child require any special assistive devices? (Check response) ☐ YES ☐ NO

If YES, please specify: _____

Does the child require any special accommodations for hor 0=no evidence of problems 1=history, mild 2=moderate 3=severe

If YES, please specify: _____

Comments: _____

_____

_____

_____

HEALTH MODULE

Child certified medically complex according to DCF policy? ☐ Yes ☐ No

Child's Current Health Status is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current Medical Conditions (check all that apply): ☐ None ☐ Allergies ☐ Asthma ☐ Diabetes ☐ Heart Disease
☐ Physical Injury ☐ Seizure Disorder ☐ Thyroid Disorder ☐ Traumatic Brain Injury ☐ Other

If other or physical injury, please specify: _____

_____

Allergies (check all that apply): ☐ Medication ☐ Food ☐ Bee Stings ☐ Latex ☐ Peanuts
☐ Other ☐ No Known

Specify details of any allergies: _____

Medical Medications: _____

_____

Describe Special Equipment, if any:_____

Describe Special Diet: _____

_____

Indicate Services/Therapies beyond scope of IEP (check all that apply):
☐ Phys. Therapy ☐ Occ. Therapy ☐ Speech ☐ N/A ☐ Other

If other, please indicate: _____ 0=no evidence of problems 1=history, mild 2=moderate 3=severe

Past Medical History_____

_____

Immunizations up to date? ☐ Yes ☐ No Date of Last TB test: _____

Date of Last Phys Exam: _____ Name of Dr./Facility/phone#:_____

Date of Last Dental Exam: _____ Name of Dentist/Facility/phone#: _____

Child's Dental Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Describe OTHER medical/dental info: _____

_____

_____

Indicate Medical and/or Dental f/u needed: _____

_____

SEXUALITY MODULE

Sex-Related Problems (*see attached coding definitions)*

	0	1	2	3	N/A
1) Promiscuity	☐	☐	☐	☐	
2) Masturbation	☐	☐	☐	☐	
3) Reactive Sexual Behavior	☐	☐	☐	☐	
4) Knowledge of Sex	☐	☐	☐	☐	
5) Choice of Relationships	☐	☐	☐	☐	
6) Sexual Identity	☐	☐	☐	☐	

Paraphilia (*see attached coding definitions)*

	0	1	2	3	N/A
7) Voyeurism	☐	☐	☐	☐	
8) Frotteurism	☐	☐	☐	☐	
9) Exhibitionism	☐	☐	☐	☐	
10) Fetishism	☐	☐	☐	☐	
11) Pedophilia	☐	☐	☐	☐	
12) Sexual masochism	☐	☐	☐	☐	
13) Sexual sadism	☐	☐	☐	☐	
14) Transvestic fetishism	☐	☐	☐	☐	

Are there any sexually deviant behaviors that are not captured in the above ratings? ☐YES ☐ NO

If yes, describe: _____

_____

What interventions have been tried that were not successful? _____

_____

_____

What interventions have been tried that were at least partially successful? _____

_____

_____

_____

SCHOOL MODULE

Current School Type: ☐ Regular ☐ Special Ed ☐ Home Instruction ☐ Clinical Day School ☐ Residential ☐ Self Contained ☐ Tech School ☐ Reg. Ed after Hours ☐ Higher Education

Name of School:_____

Grade: ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th ☐ 5th ☐ 6th ☐ 7th ☐ 8th ☐ 9th ☐ 10th ☐ 11th ☐ 12th

Date Enrolled:_____

Contact Person: _____

Address: _____ City _____ State _____ Zip _____

Phone #: _____ Email: _____

History School Type *(select all that apply):* ☐ Regular ☐ Special Ed ☐ Home Instruction ☐ Clinical Day School ☐ Residential ☐ Self Contained ☐ Tech School ☐ Reg. Ed after Hours ☐ Higher Education

	0	1	2	3	N/A	*Please rate highest level from past 30 days
*School Challenges:	☐	☐	☐	☐		Notes: _____
*School Achievement:	☐	☐	☐	☐		Notes: _____
*School Attendance:	☐	☐	☐	☐		Notes: _____
*Relation w/ Teachers:	☐	☐	☐	☐		Notes: _____

Describe the Child's School Experiences: _____

_____

_____

_____

Does child have any of the qualifying conditions? *(Select all that apply)*:

☐ Autism Spectrum Disorder ☐ Deaf-Blindness ☐ Develop. Delay 3-5yr. ☐ Emotion. Disability
☐ Hearing Impairment ☐ Spec. Learning Disability ☐ Intellectual Disability ☐ Multiple Disabilities
☐ Orthopedic Impairment ☐ Other Health Impairment ☐ Traumatic Brain Injury ☐ Visual Impairment
☐ Speech/Lang Impairment ☐ HI-ADD/ADHD ☐ To Be Determined ☐ None

Does child have a current Individualized Education Plan (IEP) in place? ☐ Yes ☐ No

CHILD STRENGTHS

0=centerpiece 1=useful 2=identified 3=not identified N= Not Assessed
Please complete notes if "0" is selected.

	0	1	2	3	N/A	
1) Family	☐	☐	☐	☐	☐	Notes: _____
2) Interpersonal	☐	☐	☐	☐	☐	Notes: _____
3) Resiliency	☐	☐	☐	☐	☐	Notes: _____
4) Educational	☐	☐	☐	☐	☐	Notes: _____
5) Vocational	☐	☐	☐	☐	☐	Notes: _____
6) Talents/Interests	☐	☐	☐	☐	☐	Notes: _____
7) Spiritual/Religious	☐	☐	☐	☐	☐	Notes: _____
8) Community Life	☐	☐	☐	☐	☐	Notes: _____
9) Relationship Permanence	☐	☐	☐	☐	☐	Notes: _____

ACCULTURATION

0=no evidence of problems 1=history, mild 2=moderate 3=severe N= Not Assessed
Please complete notes if "3" is selected

	0	1	2	3	N/A	
1) Language	☐	☐	☐	☐	☐	Notes: _____
2) Identity	☐	☐	☐	☐	☐	Notes: _____
3) Ritual	☐	☐	☐	☐	☐	Notes: _____

CAREGIVER STRENGTHS

0=strength 1=some need 2=moderate need, act 3=severe need, act immediately/intensively N=Not Assessed
Please complete notes if "0" is selected

Were other children involved? ☐ Yes ☐ No *(If No, proceed to CHILD BEHAVIORAL/EMOTIONAL NEEDS section)*

Caregiver Name: _____ Caregiver Relationship to child: _____

	0	1	2	3	N/A	
1) Supervision	☐	☐	☐	☐	☐	Notes: _____
2) Involvement	☐	☐	☐	☐	☐	Notes: _____
3) Knowledge	☐	☐	☐	☐	☐	Notes: _____
4) Organization	☐	☐	☐	☐	☐	Notes: _____
5) Social Resources	☐	☐	☐	☐	☐	Notes: _____
6) Residential Stability	☐	☐	☐	☐	☐	Notes: _____

CAREGIVER NEEDS

0=no evidence 1=some need, watch/prevent 2=moderate need, act 3=severe need, act immediately/intensively N= Not Assessed
Please complete notes if "3" is selected

	0	1	2	3	N/A	
1) Physical	☐	☐	☐	☐	☐	Notes: _____
2) Mental Health	☐	☐	☐	☐	☐	Notes: _____
3) Substance Use	☐	☐	☐	☐	☐	Notes: _____
4) Developmental	☐	☐	☐	☐	☐	Notes: _____
5) Safety	☐	☐	☐	☐	☐	Notes: _____

CHILD BEHAVIORAL/EMOTIONAL NEEDS

0=no evidence 1=history or sub-threshold, watch/prevent 2=causing problems 3=causing severe problems N= Not Assessed
Please complete notes if "3" is selected

	0	1	2	3	N/A	
1) Psychosis	☐	☐	☐	☐	☐	Notes: _____
2) Impulsivity/Hyper.	☐	☐	☐	☐	☐	Notes: _____
3) Depression	☐	☐	☐	☐	☐	Notes: _____
4) Anxiety	☐	☐	☐	☐	☐	Notes: _____
5) Oppositional	☐	☐	☐	☐	☐	Notes: _____
6) Conduct	☐	☐	☐	☐	☐	Notes: _____
7) Eating Disturbance	☐	☐	☐	☐	☐	Notes: _____
8) Anger Control	☐	☐	☐	☐	☐	Notes: _____
9) Substance Use	☐	☐	☐	☐	☐	***(Complete Substance Use Module on page 11)***
10) Adj. to Trauma	☐	☐	☐	☐	☐	***(Complete Trauma Module on page 12)***

SUBSTANCE USE DISORDER (SUD) MODULE

	0	1	2	3	N/A		0	1	2	3	N/A
1) Severity of Use	☐	☐	☐	☐		2) Duration of Use	☐	☐	☐	☐	
3) Stage of Recovery	☐	☐	☐	☐		4) Peer Influences	☐	☐	☐	☐	
5) Parental Influences	☐	☐	☐	☐		6) Environment Influences	☐	☐	☐	☐	

Specify Substance-related diagnoses: _____

_____

DRUG	ROUTE of ADMIN.	Age at 1st Use	Regular Use? (check response)	Past 48 hours? (check response)	Monthly Cost
			☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	
			☐Y ☐N	☐Y ☐N	

What Substance Abuse Treatment/Services have been tried in the past and have been helpful?

_____

_____

_____

What Substance Abuse Treatment/Services have been tried in the past have **NOT** been helpful?

_____

_____

_____

Comments: _____

_____

_____

TRAUMA MODULE

Characteristics of the Traumatic Experience(s): (*see attached coding definitions)*

	0	1	2	3	N/A		0	1	2	3	N/A
1) Sexual Abuse	☐	☐	☐	☐		*2)* Physical Abuse	☐	☐	☐	☐	
3) Emotional Abuse	☐	☐	☐	☐		4) Medical Trauma	☐	☐	☐	☐	
5) Natural Disaster	☐	☐	☐	☐		6) Witnessed Family Violence	☐	☐	☐	☐	
7) Witness to Community Violence	☐	☐	☐	☐		8) Witness/Victim to Crime	☐	☐	☐	☐	

Other Traumatic Experience(s) (e.g. natural disasters): _____

_____

If Sexual Abuse >0, complete the following: *(see attached coding definitions)*

	0	1	2	3	N/A		0	1	2	3	N/A
1) Emotion Closeness to Perpetrator	☐	☐	☐	☐		2) Frequency	☐	☐	☐	☐	
3) Duration	☐	☐	☐	☐		4) Force	☐	☐	☐	☐	
5) Reaction to Disclosure	☐	☐	☐	☐							

Adjustment: (*see attached coding definitions)*

	0	1	2	3	N/A		0	1	2	3	N/A
1) Affect Regulation	☐	☐	☐	☐		2) Intrusions	☐	☐	☐	☐	
3) Attachment	☐	☐	☐	☐		4) Dissociation	☐	☐	☐	☐	
5) Time before Treatment	☐	☐	☐	☐							

What Trauma Treatment/Services have been tried in the past and have been helpful? _____

_____

_____

_____

What Trauma Treatment/Services have been tried in the past and **NOT** been helpful? _____

_____

_____

_____

Recommendations for Treatment Approach (specify):_____

_____

_____

_____

_____

0=no evidence 1=history, watch/prevent 2=recent, act 3=acute, act immediately N= Not Assessed

Please complete notes if "3" is selected

CHILD RISK BEHAVIORS

	0	1	2	3	N/A	
1) Suicide Risk	☐	☐	☐	☐	☐	Notes: _____
2) Self-Mutilation	☐	☐	☐	☐	☐	Notes: _____
3) Other Self Harm	☐	☐	☐	☐	☐	Notes: _____
4) Reactive Sexual Behavior	☐	☐	☐	☐	☐	Notes: _____
5) Judgment	☐	☐	☐	☐	☐	Notes: _____
6) Social Behavior	☐	☐	☐	☐	☐	Notes: _____
7) Danger to Others	☐	☐	☐	☐	☐	*(**Complete Violence Module below**)*

VIOLENCE MODULE

Historical Risk Factors	0	1	2	3	N/A		0	1	2	3	N/A
History of Physical Abuse	☐	☐	☐	☐		History of Violence	☐	☐	☐	☐	
Witness to Domestic Violence	☐	☐	☐	☐		Witness to Environ. Violence	☐	☐	☐	☐	

Please describe important Historical Risk Factors: _____

_____

Emotional/Behavioral Risks	0	1	2	3	N/A		0	1	2	3	N/A
Bullying	☐	☐	☐	☐		Frustration Management	☐	☐	☐	☐	
Hostility	☐	☐	☐	☐		Paranoid Thinking	☐	☐	☐	☐	
Secondary gains from anger	☐	☐	☐	☐		Violent Thinking	☐	☐	☐	☐	

Please describe important Emotional/Behavioral Risks: _____

_____

Resiliency Factors	0	1	2	3	N/A		0	1	2	3	N/A
Awareness of Violence Potential	☐	☐	☐	☐		Response to Consequences	☐	☐	☐	☐	
Commitment to Self-Control	☐	☐	☐	☐		Treatment Involvement	☐	☐	☐	☐	

Please describe important resiliency factors that help reduce the risk of future violence: _____

_____

CHILD RISK BEHAVIORS (continued) 0=no evidence 1=History, mild 2=Moderate 3=Severe N= Not Assessed

	0	1	2	3	N/A	
8) Sexual Aggression	☐	☐	☐	☐	☐	***(Complete SAB Module below)***

SEXUALLY ABUSIVE BEHAVIOR (SAB) MODULE

Date of most recent sexually abusive behavior: _____/_____/_____

Describe the most recent behavior (include activity, circumstances, reasons and results): _____

_____

_____

_____

Was sexual act against a family member? ☐Yes ☐ No Identify _____

	0	1	2	3	N/A		0	1	2	3	N/A
Relationship	☐	☐	☐	☐		Physical Force/Threat	☐	☐	☐	☐	
Planning	☐	☐	☐	☐		Age Differential	☐	☐	☐	☐	
Type of Sex Act	☐	☐	☐	☐		Response to Accusation	☐	☐	☐	☐	
Temporal Consistency	☐	☐	☐	☐		History of Sexual Behavior	☐	☐	☐	☐	
Severity of Sexual Abuse	☐	☐	☐	☐		Prior Treatment	☐	☐	☐	☐	

Is the youth currently subject to the provisions of Megan's Law? ☐ YES ☐ NO

What Specialty Sexual Aggression Treatment/Services have been tried in the past and have been helpful?

_____

_____

What Specialty Sexual Aggression Treatment/Services have been tried in the past and **NOT** been helpful?

_____

_____

Recommendations for Treatment Approach: _____

_____

CHILD RISK BEHAVIORS *(continued)*

0=no evidence 1=History, mild 2=Moderate 3=Severe N=Not Assessed

	0	1	2	3	N/A
9) Runaway	☐	☐	☐	☐	☐

(Complete Runaway Module below)

RUNAWAY MODULE

	0	1	2	3	N/A		0	1	2	3	N/A
Frequency of Running	☐	☐	☐	☐		Consistency of Destination	☐	☐	☐	☐	
Safety of Destination	☐	☐	☐	☐		Involvement in Illegal Activity	☐	☐	☐	☐	
Likelihood of Return on Own	☐	☐	☐	☐		Involvement of Others	☐	☐	☐	☐	
Realistic Expectations	☐	☐	☐	☐		Planning	☐	☐	☐	☐	

To what locations has child run in the past?_____

_____

_____

How do you understand the running behaviors? _____

_____

_____

What reasons has the youth given for running in the past? _____

_____

_____

In the past, what does the youth do while on run? _____

_____

_____

Has any approach been successful in the past in h 0=no evidence 1=History, mild 2=Moderate 3=Severe N= Not Assessed

_____

_____

_____

JUVENILE JUSTICE (JJ) MODULE

Date of most recent delinquent behavior: _____/_____/_____

	0	1	2	3	N/A		0	1	2	3	N/A
Seriousness	☐	☐	☐	☐		History	☐	☐	☐	☐	
Planning	☐	☐	☐	☐		Community Safety	☐	☐	☐	☐	
Peer Influences	☐	☐	☐	☐		Parental Criminal Behavior	☐	☐	☐	☐	
Environmental Influences	☐	☐	☐	☐		Age Engaged in Criminal Beh.	☐	☐	☐	☐	
Use of Free Time to Engage	☐	☐	☐	☐		Aggression/Temper Level	☐	☐	☐	☐	
Substance Use/Delinquent Behavior	☐	☐	☐	☐		Educational Goals/Aspirations	☐	☐	☐	☐	
Parental Supervision	☐	☐	☐	☐							

During the past year has the youth committed acts of delinquency against property? ☐ YES ☐ NO

If YES, please specify: _____

During the past year has the youth committed acts of delinquency against people? ☐YES ☐ NO

If YES, please specify: _____

Has the youth used a weapon in the commission of an act of delinquency? ☐ YES ☐ NO

If YES, please specify: _____

Has the youth committed any acts of delinquency involving illegal substances? ☐ YES ☐ NO

If YES, please specify: _____

Describe any current court orders: _____

_____

Parole Officer: _____ Phone: _____

Probation Officer: _____ Phone: _____

Current Living Situation of Youth: _____

Please list dates Admissions to Detentions and/or Mansion/York, if any: _____

_____

_____

CHILD RISK BEHAVIORS *(continued)* 0=no evidence 1=History, mild 2=Moderate 3=Severe N=Not Assessed

	0	1	2	3	N/A
11) Fire Setting	☐	☐	☐	☐	☐

(Complete Fire-Setting Module Below)

FIRE SETTING MODULE

Date of most recent fire-setting behavior _____/_____/_____

Describe the incident including circumstances, reasons, frequency and results/damage:_____

_____

_____

_____

Was the child alone at the time of the incident? ☐ Yes ☐ No

Specify: _____

_____

Were other children involved? ☐ Yes ☐ No

Specify: _____

_____

Rate the child on the following dimensions based on their most recent fire-setting behavior and any prior history of similar behaviors

	0	1	2	3	N/A
Seriousness	☐	☐	☐	☐	
Planning	☐	☐	☐	☐	
Intention to Harm	☐	☐	☐	☐	
Response to Accusation	☐	☐	☐	☐	
Likelihood of future fires	☐	☐	☐	☐	

	0	1	2	3	N/A
History	☐	☐	☐	☐	
Use of accelerants	☐	☐	☐	☐	
Community Safety	☐	☐	☐	☐	
Remorse	☐	☐	☐	☐	

Highlight/detail any pertinent evaluation and identified risk of future fire-setting: _____

_____

_____

_____

_____

Any current or history of psychotropic medication used? ☐ YES ☐ NO (***If yes, complete Medication module below)***

MEDICATION MODULE

List all current meds – Name, Dosage, Frequency:_____

_____

_____

_____

List all past psychotropic meds, Name, Dosage, Frequency:_____

_____

_____

_____

Describe any Allergies/adverse reactions to psychotropic medications:_____

_____

_____

Prescribing Psychiatrist: _____ Phone:_____

Address: _____

CURRENT & HISTORY STATUS/INVOLVEMENT *(check all that apply):*

***Current or past child welfare involvement?** ☐ Yes ☐ No

***Current or past family with service needs?** ☐ Yes ☐ No

***Current or past JJ Probation?** ☐ Yes ☐ No

***Current or past JJ Parole?** ☐ Yes ☐ No

***Current or past Mental Health Services?** ☐ Yes ☐ No

***DDS (Current):** ☐ None ☐ Pending ☐ Accepted/No services ☐ Accepted/with Services

For any checked, name facility/agency/provider and date of service (start and end):_____

_____

_____

***DMHAS:** ☐ None ☐ Pending ☐ Accepted/No services ☐ Accepted/with Services

*For any checked, name facility/agency/provider and date of service (start and end):

_____

_____

_____

*What Treatment/Interventions/Services have been tried in the past and have been helpful?

_____

_____

_____

*GENERAL NOTES:

_____

_____

_____

_____

_____

_____