# Nevada Division of Child and Family Services Mental Health Admission

**Call Intake**

| **Client Name [LAST, First MI]** | | | **Avatar MR#:** | |
| --- | --- | --- | --- | --- |
| Screening Date:    /   /      Statement of Problem and Comments: | | | | |
| *Disposition:* | *Intake date:* | *Intake time:* | | *Intake with:* |

# Client Financial/Insurance Coverage [an additional Financial/Benefit form may also be completed]

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| Medicaid Number: | Medicaid Fee for Service | Medicaid Managed Care: | |
| Private Insurance: | No Insurance | | Total # in Household: |

**Client Admission**

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| Admission Date:    /   / | Admission Type: Admitting Practitioner: |
| Program:  Source of Admission: | |
| **Primary Presenting Problems**   |  |  |  | | --- | --- | --- | | Primary A – F:  F – Z : | Secondary A – F:  F – Z: | Tertiary A – F:  F – Z: |   **Client Demographics**   |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Identified Gender: | | Date of Birth:    /   / | | Social Security #: | | | | | | | Address: | | Bldg/Apt#: | City: | | County: | | | | Zip: | | Home Phone: | Cell Phone: | | Other Phone: | | | | UNITY # (if applicable) : | | | | Primary Language: | Spoken in the Home: | | Interpreter needed? | | | | | Language: | | | Country of Origin: | Place of Birth: | | US Citizen: | | | | Alien Registration #: | | | | Primary Race: | | | Secondary Race (if applicable): | | | | | | | | Ethnicity: | Homeless Indicator: | | | | | Custody: | | | | | |
| | **Client Name [LAST, First MI]** | **Avatar MR#:** | | --- | --- |   **Demographic/Healthcare Coverage Status**   |  | | --- | | U.S. Legal Status: Client Parent 1 Parent 2  Have you applied for any of the following?: \*If yes, what was the outcome?:  Medicaid  NV Check Up  Health insurance via the Affordable Care Act  (AKA Obamacare), NV Healthcare Exchange/ NV Health Link  I have not applied for insurance in past 3 months  \*If no, why not?  Did not meet eligibility requirements  Cannot afford the premiums  Do not know how to apply  New to the state, haven’t applied yet  Recently lost coverage, haven’t reapplied  Not interested in having insurance  Other (comments): |   **Legal (Custody) Status**   |  |  | | --- | --- | | Effective Date:   /  / | Legal Status: |  Previous Health Care Treatment  |  |  | | --- | --- | | Previous Treatment Type: | | | Facility Name(s): | Reason for Services: |  Supplemental Client Information  |  |  |  |  | | --- | --- | --- | --- | | School Name: | Grade: | Grade Date:   /  / | SPED/IEP:  Yes  No |  Referral Information  |  | | --- | | Primary Referral Source Code:  Referring Provider:  Primary Referral Source Contact:       Contact Phone: |   **SED Determination**   |  |  |  | | --- | --- | --- | | SED  Yes  No | Date:    /   / | SED Determination made by: |  Supplemental Assessments  |  |  |  |  | | --- | --- | --- | --- | | Date:    /   / | | Assessing Practitioner: | | | CASII Score: | ECSII Score: | CAFAS Score: | PECFAS Score: |  Diagnoses – DSM 5  |  |  |  |  |  | | --- | --- | --- | --- | --- | | Date:    /   /      Time of Diagnosis:        am  pm Diagnosing Practitioner: | | | | | | Diagnosis Code: | Description: | | | Classification: | | Diagnosis Code:  Diagnosis Code: | Description: | | | Classification: | | Description: | | | Classification: | | Diagnosis Code: | Description: | | | Classification: | | Diagnosis Code: | Description: | | | Classification: | | **Primary Diagnosis Code**  [pick from list above]: | | **Secondary Code:** | **Tertiary Code:** | |   **Diagnoses – DC: 0-3R**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Date:    /   / | Time of Diagnosis:        am  pm | | | Diagnosing Practitioner: | | Diagnosis Code Axis I (**Primary Classification**): | |  | Description: | | | Diagnosis Code Axis I:       Description:  Diagnosis Code Axis I:       Description:  Diagnosis Code Axis II (*Relationship Quality/ PIR-GAS score*):  over involved  anxious/tense  physically abusive  sexually abusive  under involved  angry/hostile  verbally abusive  other: | | | | | | |

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| **DSM 5 Level 1 Cross-Cutting Symptom Measure (Child Age 6-17)**  0=None/not at all 1=Slight/rare (less than a day or two) 2=Mild/several days 3=Moderate/more than half the days 4=Severe/nearly every day | | | | | |
| DURING THE PAST TWO (2) WEEKS, HOW MUCH/OFTEN HAS YOUR CHILD...(Rating scale 0-4) | | | **SCREENING** |  | **INTAKE** |
| I. | 1 | Complained of stomachaches, headaches, or other aches and pains? | Select One |  | Select One |
| 2 | Said he/she was worried about his/her health or about getting sick? | Select One |  | Select One |
| II. | 3 | Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early? | Select One |  | Select One |
| III. | 4 | Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game? | Select One |  | Select One |
| IV. | 5 | Had less fun doing things than he/she used to? | Select One |  | Select One |
| 6 | Seemed sad or depressed for several hours? | Select One |  | Select One |
| V. & VI. | 7 | Seemed more irritated or easily annoyed than usual? | Select One |  | Select One |
| 8 | Seemed angry or lost his/her temper? | Select One |  | Select One |
| VII. | 9 | Started lots more projects than usual or did more risky things than usual? | Select One |  | Select One |
| 10 | Slept less than usual for him/her, but still had lots of energy? | Select One |  | Select One |
| VIII. | 11 | Said he/she felt nervous, anxious, or scared? | Select One |  | Select One |
| 12 | Not been able to stop worrying? | Select One |  | Select One |
| 13 | Said he/she couldn’t do things he/she wanted to or should have done, because they made him/her feel nervous? | Select One |  | Select One |
| IX. | 14 | Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her? | Select One |  | Select One |
| 15 | Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see? | Select One |  | Select One |
| X. | 16 | Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else? | Select One |  | Select One |
| 17 | Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off? | Select One |  | Select One |
| 18 | Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned? | Select One |  | Select One |
| 19 | Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening? | Select One |  | Select One |
| WITHIN THE PAST TWO (2) WEEKS, HAS YOUR CHILD… (“Yes”, “No”, or “Don’t Know”) | | | **SCREENING** |  | **INTAKE** |
| XI. | 20 | Had an alcoholic beverage (beer, wine, liquor, etc.)? | Select One |  | Select One |
| 21 | Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco? | Select One |  | Select One |
| 22 | Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)? | Select One |  | Select One |
| 23 | Used any medicine without a doctor’s prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)? | Select One |  | Select One |
| XII. | 24 | In the past TWO (2) WEEKS, has he/she talked about wanting to kill himself/herself or about wanting to commit suicide? | Select One |  | Select One |
| 25 | Has he/she EVER tried to kill himself/herself? | Select One |  | Select One |

| **Client Name [LAST, First MI]** | **Avatar MR#:** |
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| | **Client Name [LAST, First MI]** | **Avatar MR#:** | | --- | --- |   **DCFS Contacts and Responsible Person (s)** |
| |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Start Date:    /   / | Name: | | | | Relationship to Client: | | | | | Marital Status: | DOB:    /   / | | Social Security #: | | | | Phone number: | | | **Role**  Parent  Responsible Person  Guardian  Primary Contact | | | | | | | | | | Address: | | Bldg./Apt#: | | City: | | County: | | Zip: | |
| |  |  | | --- | --- | | **Primary Insurance Coverage:** | **Secondary Insurance Coverage:** | | Insurance: | Insurance: | | Policy #: | Policy #: | | Group #: | Group #: | | Policy Holder: | Policy Holder: | | Policy Holder’s SS#: | Policy Holder’s SS#: | | Policy Holder’s Date of Birth:    /   / | Policy Holder’s Date of Birth:    /   / | | Relationship to Insured: | Relationship to Insured: | | Prescription Drug coverage: | Prescription Drug Coverage: |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | | Start Date:    /   / | Name: | | | | Relationship to Client: | | | | | Marital Status: | DOB:    /   / | | Social Security #: | | | | Phone number: | | | **Role**  Parent  Responsible Person  Guardian  Primary Contact | | | | | | | | | | Address: | | Bldg./Apt#: | | City: | | County: | | Zip: | | Start Date:    /   / | Name: | | | | Relationship to Client: | | | | | Marital Status: | DOB:    /   / | | Social Security #: | | | | Phone number: | | | **Role**  Parent  Responsible Person  Guardian  Primary Contact | | | | | | | | | | Address: | | Bldg./Apt#: | | City: | | County: | | Zip: | | Start Date:    /   / | Name: | | | | Relationship to Client: | | | | | Marital Status: | DOB:    /   / | | Social Security #: | | | | Phone number: | | | **Role**  Parent  Responsible Person  Guardian  Primary Contact | | | | | | | | | | Address: | | Bldg./Apt#: | | City: | | County: | | Zip: |   **DOES THIS CHILD HAVE MEDICAL INSURANCE COVERAGE?** (Medicaid included) The State of Nevada is not a provider under any HMO or Preferred Provider insurance, therefore all clients with an HMO or Preferred Provider insurance will be referred to seek services from providers covered by their insurance plan. |
| NO - If no, please initial here and skip to the signature section \_\_\_ (initial). |
| YES - Please read and complete the following section: |
| I understand that the Division of Child and Family Services cannot guarantee that any insurance company will accept either the diagnosis or treatment given to the youth or the credentials of the clinical staff member who rendered the services. |
| I further understand that if my insurance company pays insurance benefits directly to me I will, in turn, pay that amount to DCFS immediately. |
| **I authorize payment of medical benefits to the STATE OF NEVADA, DIVISION OF CHILD AND FAMILY SERVICES.**  **I also authorize the release of any medical or other information necessary to process this claim.** | |
| I agree to show/provide a copy of my insurance ID card (front and back) and/or the youth’s current Medicaid card at this time. | |
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|  | |
| ***Signature of Responsible Person Date*** | |
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|  | |
| Signature of DCFS Staff Person Title Date | |
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