

**In-Home Family Treatment (H2011)  
Screening Instrument  
Ver. 1/2007**

Child's Name: \_\_\_\_\_ Referring Agency: \_\_\_\_\_  
Child's DOB: \_\_\_\_\_ FC/JJA Case Manager: \_\_\_\_\_  
FC/JJA Case Manager Phone #: \_\_\_\_\_

Name of person completing this form: \_\_\_\_\_

1. Has the child been determined to be SED? YES  NO

If YES, proceed to next question.

If NO, then the child is not eligible for this service.

2. Is the youth experiencing functional impairment as a result of their mental illness in their current placement that requires a service to remedy the family problems which contribute to the symptoms of the mental illness or their functional impairment?  
YES  NO

3. List the specific functional impairments that the youth is exhibiting (as it relates to their mental illness) that it is believed can best be impacted by In-Home Family Treatment:

\_\_\_\_\_

4. List the specific family problems that are believed to be contributing to this child's emotional disturbance:

\_\_\_\_\_

5. List previously received mental health services that were not successful in resolving the issues listed in #3 and #4:

\_\_\_\_\_

6. Has the family that the child is currently living with received Family Therapy? If yes explain the results of that intervention – if no explain why clinic based services are not being tried first)  YES  NO

\_\_\_\_\_

7. Date of most recent CAFAS Scores: \_\_\_\_\_  
(must be less than 30 days old- follow Up CAFAS should utilize a 30 day time frame for rating the criteria):

Total Score:	_____		
Home:	_____	Self-Harm:	_____
School:	_____	Substance Use:	_____
Behavior towards others:	_____	Thinking:	_____
Community:	_____		
Moods:	_____		

**In-Home Family Treatment (H2011)**

**Screening Instrument (Ver. 1/2007)**

**Page 2**

**8. Please explain why In-Home Family Treatment is believed to be the most effective treatment intervention at this time and what result it is believed this intervention will achieve:**

\_\_\_\_\_

---

**FOR CMHCCC USE ONLY:**

**Request for Initial Authorization has been approved for \_\_\_\_\_ units**

**Request for Initial Authorization has not been approved for the following reasons:**

\_\_\_\_\_

**Other Treatment Recommendations:**

\_\_\_\_\_

**Date:** \_\_\_\_\_

**CMHC QMHP:** \_\_\_\_\_