



Uniform Assessment Form
Department of State Health Services

Rev. 11/07

Child & Adolescent Evaluation Assessment for Resiliency & Disease Management

NorthSTAR ID <input type="text"/>	NPI Number <input type="text"/>
Last Name <input type="text"/>	Provider Number <input type="text"/>
First Name <input type="text"/>	Vendor Number Location <input type="text"/>
Middle Name <input type="text"/>	Katrina evacuee? Y/N Original Parrish name:

Assessment Type: Intake <input type="checkbox"/> Discharge <input type="checkbox"/> Crisis (temporary) <input type="checkbox"/>	Intake Non-Admission <input checked="" type="checkbox"/> Reason for Discharge _____	Update <input type="checkbox"/> Discharge Date <input type="text"/> - <input type="text"/> - <input type="text"/> <small>MM DD YYYY</small>
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Referral Source <input type="checkbox"/>	At Risk of Placement <input type="checkbox"/>	ED (Special Education) <input type="checkbox"/>
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Action Type: Add ___ Correct/Modify ___ Delete ___

Section 1: Child/Adolescent TRAG
(Completed by Provider QMHP staff)
Diagnostic Qualifier (I, E, or N) _____

A. Ohio Scales

1a. Parent Ohio Problem Severity Scale Score (0-100) _____

1b. Parent Ohio Functioning Scale Score (1-80) _____

2a. Youth Ohio Problem Severity Scale Score (0-100) _____

2b. Youth Ohio Functioning Scale Score (0-80) _____

3a. Worker Ohio Problem Severity Scale Score (0-100) _____

3b. Worker Ohio Functioning Scale (0-80) _____

B. CA-TRAG Dimension Ratings
(All dimensions must be completed.)

1. Problem Severity – Ohio Problem Severity Scale Score	<input checked="" type="checkbox"/>
2. Functioning – Ohio Functioning Scale Score	<input checked="" type="checkbox"/>
3. Risk of Self-Harm	1 2 3 4 5
4. Severe Disruptive or Aggressive Behavior	1 2 3 4 5
5. Family Resources	1 2 3 4 5
6. History of Psychiatric Treatment	1 2 3 4 5
7. Co-occurring Substance Use	1 2 3 4 5
8. Juvenile Justice Involvement	1 2 3 4 5
9. School Behavior	1 2 3 4 5
10. Psychoactive Medication Treatment?	<input type="checkbox"/>

C. Successfully Completed CA Service Package 1 or 2?

D. Level of Care Decisions
Calculated Level of Care Recommendation (LOC-R)

E. TCOOMMI Consumer?

F. Extended Review Period Requested
(LOC-A Service Packages 4 only)

G Assessment Date --
MM DD YYYY

Assessed By: _____ Credentials _____

Section 2: Community Data
(Completed by Provider QMHP staff)

A. Number of Arrests in the Last 90 Days _____

B. School Days Missed in the Last 90 Days _____

C. Primary Residence Type during the Last 90 Days
(Circle one)

1 = Private Residence (Individual or Family's Own House or Apartment)
 2 = Foster Care (Foster Care/Therapeutic Foster Care)
 3 = Residential Care (Group Home/Assisted Living/Rehab Center)
 4 = Crisis Residential
 5 = Children's Residential Treatment Facility
 6 = Institutional Setting (Nursing Home/Intermediate Care Facility/Hospital)
 7 = Jail or Correctional Facility (Juvenile Justice/Jail/Correctional Facility)
 8 = Homeless (Homeless/Shelter/Runaway/"Couch-surfing")
 9 = Other

D. Assessment Date --
MM DD YYYY

Notes: _____

Section 3
Completed by ValueOptions

Description		DSM Code
AXIS I	Level 1	_____
	Level 2	_____
	Level 3	_____
AXIS II	Level 1	_____
	Level 2	_____
	Level 3	_____

OPTIONAL (AXIS III & IV)

		ICD Code
AXIS III	Level 1	_____
	Level 2	_____
	Level 3	_____
	Level 4	_____
	Level 5	_____
	Level 6	_____
AXIS III Date: ____ - ____ - ____		

AXIS IV: (Check all that apply) ___A ___B ___C ___D ___E ___F ___G ___H ___I

AXIS V: Current: _____ Past Year: _____

Authorized Level Of Care (LOC-A):

Please Check the Box to Indicate Request:

- Service Package 1.1
- Service Package 1.2
- Service Package 2.2
- Service Package 2.3
- Service Package 2.4
- Service Package 4
- Service Package 5

Information Box
Provider Number: _____
Vendor Number Location: _____
Member NorthSTAR ID: _____
Form Completion Date: ____ - ____ - ____

MH Child/Adolescent Evaluation Assessment for Resiliency & Disease Management (NorthSTAR)

Field Name	Type	Contents
NORTHSTAR NUMBER	R	NorthSTAR Member number.
LAST NAME	R	Consumer's last name.
FIRST NAME	R	Consumer's first name.
MIDDLE NAME	O	Consumer's middle name.
NPI NUMBER	R	National Provider Identifier number.
PROVIDER NUMBER	R	BHO 6 Digit Assigned Provider Number
VENDOR NUMBER LOCATION COMPONENT	R	BHO 6 DIGIT ASSIGNED VENDOR NUMBER (WHERE SERVICE IS PROVIDED SPECIFIC TO LOCATION) North Star component code is 085.
ASSESSMENT TYPE: CRISIS	O/R	Check this box if the purpose of the assessment is to record that the consumer is receiving crisis services and not currently enrolled in a service package. Note: Crisis is no longer an Intake assessment type.
ASSESSMENT TYPE: INTAKE	O/R	Check this box if the purpose of the assessment is the consumer's intake to services.
ASSESSMENT TYPE: INTAKE NON-ADMISSION	----	This option will be automatically entered by the WebCARE screens if the purpose of the assessment is a non-admission due to ineligibility or refusal of services.
ASSESSMENT TYPE: UPDATE	O/R	Check this box if the purpose of the assessment is to update the person's care.
ASSESSMENT TYPE: DISCHARGE REASON FOR DISCHARGE	O/R	Check this box if the purpose of the assessment is the person's discharge.
DISCHARGE DATE	O/R	If discharge, indicate the code that best describes the discharge reason (A=Age 18 or older, C=Level of Care services complete, J=Texas Youth Commission (TYC), M=Moved out of local service area, N=Never Returned for Services within Authorized Service Period, not to exceed 90 days, P = Elected a new provider, E = Change in NorthSTAR eligibility , Z= Other.) If the assessment purpose is discharge, indicate the date of discharge.
INTAKE: REFERRAL SOURCE	R	Select the source that first prompted or suggested the referral (1=Family/Self, 2=School, 3=Juvenile Probation, 4=Texas Youth Commission (TYC), 5=Child Protective Services (CPS), 6=Another division within the center-MR/SA/Emergency Services, 7=MH facility, 8=Other, 9=Unknown).
AT RISK OF PLACEMENT	O/R	Check this box if the child meets one of the following: 1) history of residential/hospital placement for mental health treatment; 2) the LAR/caregiver considers residential/hospital placement for mental health treatment a solution; or 3) the child is returning from residential/hospital placement for mental health treatment. Check this box if the child meets at least two of the following: 1) history of school trancies; 2) history of serious alcohol/drug use; 3) history of serious behavioral problems at school; 4) history of delinquent behaviors in the community; 5) history of serious parental/caregiver rejections; and 6) history of serious behavioral problems at home.
ED (SPECIAL EDUCATION)	O/R	Check this box only if the child is designated special education by the school because of emotional disturbance.
ACTION TYPE: ADD	O/R	Check this line to add a new Evaluation Assessment for the first time.
ACTION TYPE: CORRECT/MODIFY	O/R	Check this line to correct or modify information that has been previously submitted.
ACTION TYPE: DELETE	O/R	Check this line to delete a previously submitted form that was incorrect.
Section 1: Child/Adolescent TRAG – Completed by LMHA QMHP at Intake or Provider QMHP at Update.		
DIAGNOSTIC QUALIFIER	O/R	Enter E (xternalizing), I (nternalizing), or N (ot yet stabilized) if the child/adolescent has been diagnosed with one of the following DSM-IV codes: 293.0; 293.81; 293.82; 295.1-295.3; 295.4; 295.6; 295.7; 295.9; 296.00-296.06; 296.24; 296.34; 296.4-296.46; 296.5-296.56; 296.6-296.66; 296.7; 296.8; 296.89; 296.9; 297.1; 297.3; 298.8; 298.9; 301.13; 309.4; or 780.09 only.
A. OHIO SCALES	R	Enter 1-100 for Problem Severity Scale score and 1-80 for Functioning Scale score.
1.A. AND 1.B. PARENT SCALES	O/R	Preferred. Parent responses to Ohio Scales.
2.A. AND 2.B. YOUTH SCALES	O	Consumer's responses to Ohio Scales.
3.A. AND 3.B. WORKER SCALES	O/R	Use QMHP's responses only if the parent cannot or refuses to complete the scale scores.
B. CA-TRAG DIMENSION RATINGS		
1-2	D	Displays the Ohio Scores from Section 1, A. that will be used to calculate the LOC-R.
3-9	R	Indicate the individual rating for each of the Child/Adolescent-TRAG (1=No Notable Limitations to 5=Extreme Limitations).
10 PSYCHOACTIVE MED. TREATMENT?	O/R	Check this box if the consumer is receiving psychoactive medication treatment.
C. SUCCESSFULLY COMPLETED SP 1,2, OR 3?	O/R	Check this box if the consumer has completed child/adolescent service package 1, 2 or 3.
D. CALCULATED LEVEL OF CARE RECOMMENDED	D	Displays the Child/Adolescent-TRAG Level of Care Recommendation (LOC-R) that is automatically calculated from responses to Section 1, B.

E. TCOOMMI CONSUMER?	O	Check this box if the consumer receives services through a Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) contract.
F. ASSESSMENT DATE	R	Date of the Child/Adolescent TRAG completion in MMDDYYYY format.
ASSESSED BY	R	Name of the person completing Section 1.
CREDENTIALS	R	Highest credentials of the person completing Section 1 (QMHP-CS, RN, LCSW, LMSW-ACP, LMFT, LPC, LPHD-Psy, RN-APN, PA, MD, DO). LVN is not approved to complete Section 1.
NOTES	O	Used for provider/authority communication and clinical notes. Limited to 6 lines or less.

Section 2: Community Data – Completed by Provider QMHP staff.

A. NUMBER OF ARRESTS IN LAST 90 DAYS?	R	Enter the number of times the consumer has been arrested in the last 90 days. Enter 0 if none.
B. SCHOOL DAYS MISSED IN LAST 90 DAYS?	R	Enter the number of days the consumer has missed school during the last 90 days. Exclude holidays and breaks. Enter 0 if none.
C. PRIMARY RESIDENCE TYPE –LAST 90 DAYS	R	Indicate the primary residence type for the consumer during the last 90 days.
D. ASSESSMENT DATE	R	Date the community data was collected in MMDDYYYY format.
NOTES	O	Used for the name and credentials of the staff responsible for completion of this section or for provider/authority communication. Limited to 6 lines or less.

PAGE 2: DIAGNOSIS FORM – COMPLETED BY LVN OR QMHP STAFF.

FOR NON-SUBSTANCE RELATED MENTAL HEALTH DIAGNOSIS

* PRINCIPAL DIAGNOSIS AXIS	R	CONSUMER'S PRINCIPAL DIAGNOSIS
* AXIS I	O/R	PSYCHIATRIC SYNDROME
* AXIS II	O/R	PERSONALITY AND SPECIFIC DEVELOPMENTAL DISORDER OR MENTAL RETARDATION (SEE THE CURRENT OFFICIAL DSM-IV MANUAL FOR DIAGNOSTIC CODES)
* AXIS I DIAGNOSIS	O/R	LEVEL 1 IS REQUIRED IF THE PRINCIPAL DIAGNOSIS AXIS FIELD IS MARKED. LEVEL 1 IS MOST SIGNIFICANT. PLEASE PRINT THE NARRATIVE DESCRIPTIONS FOR EACH LEVEL IN BLOCK CAPITAL LETTERS. (ALL THREE DO NOT HAVE TO BE COMPLETED.)
*AXIS II DIAGNOSIS	O/R	LEVEL 1 IS REQUIRED IF THE PRINCIPAL DIAGNOSIS AXIS FIELD IS MARKED. LEVEL 1 IS MOST SIGNIFICANT. PLEASE PRINT THE NARRATIVE DESCRIPTIONS FOR EACH LEVEL IN BLOCK CAPITAL LETTERS. (ALL THREE DO NOT HAVE TO BE COMPLETED.)
* AXIS III	O/R	THERE ARE SIX FIELDS FOR RECORDING ICD-9 CODES REPRESENTING THE CONSUMER'S PHYSICAL DIAGNOSES. LEVEL 1 IS MOST SIGNIFICANT. DOCUMENT ANY IDENTIFIED PHYSICAL DIAGNOSIS. PLEASE PRINT THE NARRATIVE DESCRIPTIONS FOR EACH LEVEL IN BLOCK CAPITAL LETTERS. (SEE THE CURRENT OFFICAL ICD-9 MANUAL FOR DIAGNOSTIC CODES.)
* AXIS III DATE	R	DATE OF THE PHYSICIAN'S EXAMINATION IN WHICH THE AXIS III
* AXIS IV	O/R	Indicate the individual rating for each of the psychosocial and environment problems A through I. (No selection will indicate no perceived problem.)
* AXIS V	O/R	Indicates consumer's psychological, social, and occupational functioning. (Do not include impairment in functioning due to physical or environmental limitations.)
* AXIS V Current		Write in two-digit code to identify the consumer's current level of adaptive functioning.
* AXIS V Past Year		Write in two-digit code to identify the consumer's highest level of adaptive functioning in the past year. For children and adolescents, this should include at least a month during the school year.