

# CBITS Client Face Sheet: Intake

## VALIDATION REQUIREMENTS AND SYMBOLS EXPLAINED

- !** This symbol means the field is one of the minimum fields that must be filled out to save the record. No data will be saved unless these fields are completed.
- \*** This symbol means the field is a required field in order to save the record as completed. Although you can save the record, the system does not consider the record to be completed unless ALL of these fields are completed.

## Direct Service Provider User Information

<b>Clinician First and Last Name: !</b>			
<b>Provider Name: !</b>		<b>Site Name: !</b>	

## Child Information

<b>First Initial Child's First Name: !</b>		<b>First Initial Child's Last Name: !</b>	
<b>Date of Birth: !</b>		<b>Age:</b>	
<b>Sex: !</b>	<input type="checkbox"/> Female	<input type="checkbox"/> Intersex	
	<input type="checkbox"/> Male	<input type="checkbox"/> Other (specify)→	
<b>Grade (current): *</b>			
<b>Race: *</b>	<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Black or African American	<input type="checkbox"/> White
	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian or Other Pacific Islander	<input type="checkbox"/> Other (specify)
<b>Hispanic Origin: *</b>	<input type="checkbox"/> Yes, Cuban	<input type="checkbox"/> Yes, of Hispanic/Latino Origin	<input type="checkbox"/> Yes, South or Central American
	<input type="checkbox"/> Yes, Mexican, Mexican American, Chicano	<input type="checkbox"/> Yes, Puerto Rican	<input type="checkbox"/> No, Not of Hispanic, Latino, or Spanish Origin
<b>City/town:</b>		<b>ST:</b>	<b>Zip: *</b>

## Child Identification Codes

<b>Agency-assigned Client ID Number (not PHI): !</b>		<b>PSDCRS Client ID Number: !</b>	
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## Family Information

<b>Caregiver 1 Relationship: *</b>		<b>Caregiver 2 Relationship:</b>	
<b>Preferred Language of Adult Participating in Treatment: *</b>			
<b>Does the adult participating in treatment speak English?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Primary Language of Child:</b>			
<b>Family Composition: *</b> Select the choice that best describes the composition of the family.	<input type="checkbox"/> Two parent family	<input type="checkbox"/> Single parent - biological/adoptive parent	<input type="checkbox"/> Relative/guardian
	<input type="checkbox"/> Single Parent with unrelated partner	<input type="checkbox"/> Blended Family	<input type="checkbox"/> Other

<b>Living Situation of Child: *</b> What is the child's living situation?	<input type="checkbox"/>	College Dormitory	<input type="checkbox"/>	Job Corps	<input type="checkbox"/>	Psychiatric Hospital
	<input type="checkbox"/>	Crisis Residence	<input type="checkbox"/>	Medical Hospital	<input type="checkbox"/>	Residential Treatment Facility
	<input type="checkbox"/>	DCF Foster Home	<input type="checkbox"/>	Mentor	<input type="checkbox"/>	TFC Foster Home (privately licensed)
	<input type="checkbox"/>	Group Home	<input type="checkbox"/>	Military Housing	<input type="checkbox"/>	Transitional Housing
	<input type="checkbox"/>	Homeless/Shelter	<input type="checkbox"/>	Other (specify):		
	<input type="checkbox"/>	Jail/Correctional Facility	<input type="checkbox"/>	Private Residence		

**System Involvement**

<b>Child/Family involved with DCF? *</b>	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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**If child / family is involved with DCF, please complete ALL of the following questions:**

<b>DCF Case ID: (if available)</b>		<b>DCF Person Link ID: (if available)</b>				
<b>DCF Status:</b>	<input type="checkbox"/>	Child Protective Services – In-Home	<input type="checkbox"/>	Family with Service Needs – (FWSN) In-Home	<input type="checkbox"/>	Not DCF – On Probation
	<input type="checkbox"/>	Child Protective Services – Out of Home	<input type="checkbox"/>	Family with Service Needs (FWSN) Out of Home	<input type="checkbox"/>	Not DCF – Other Court Involved
	<input type="checkbox"/>	Dual Commitment (JJ and Child Protective Services)	<input type="checkbox"/>	Juvenile Justice (delinquency) commitment	<input type="checkbox"/>	Termination of Parental Rights
	<input type="checkbox"/>	Family Assessment Response	<input type="checkbox"/>	Not DCF	<input type="checkbox"/>	Voluntary Services Program

<b>DCF Regional Office:</b>	
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<b>Youth involved with Juvenile Justice (JJ) System? *</b>	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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**If youth is involved with JJ, please complete ALL of the following questions:**

<b>CSSD Client ID: (if available)</b>		<b>CSSD Case ID: (if available)</b>				
<b>CSSD Case Type:</b>	<input type="checkbox"/>	Delinquency	<input type="checkbox"/>	Family with Service Needs (Status Offense)		
	<input type="checkbox"/>	Administrative Supervision	<input type="checkbox"/>	Juvenile probation	<input type="checkbox"/>	Restore Probation
<b>CSSD Case Status:</b>	<input type="checkbox"/>	Extended Probation	<input type="checkbox"/>	Non-Judicial FWSN Family Service Agreement	<input type="checkbox"/>	Suspended Order
	<input type="checkbox"/>	Interim Orders	<input type="checkbox"/>	Non-Judicial Supervision (NJS)	<input type="checkbox"/>	Waived PDS - Probation
	<input type="checkbox"/>	Judicial FWSN Supervision	<input type="checkbox"/>	Non-Judicial Supervision Agreement	<input type="checkbox"/>	

<b>Court District:</b>	
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<b>Court Handling Decision:</b>	<input type="checkbox"/>	Judicial	<input type="checkbox"/>	Non-Judicial
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**Specific Treatment Information**

<b>What treatment model are you using with this child? *</b>	<input checked="" type="checkbox"/>	CBITS	<input type="checkbox"/>	MATCH-ADTC
	<input type="checkbox"/>	TF-CBT	<input type="checkbox"/>	Bounce Back

<b>First CBITS Clinical Session Date: *</b> Date of first EBP clinical session	
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**Treatment Information**

<b>Agency Referral Date/Request for Service: *</b> Date child was referred to agency		<b>Agency Intake Date: *</b> What is the intake date for the client at the agency?	
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<b>CBITS Referral Date: *</b> Date the child was referred for EBP services						
<b>CBITS Referral Source: *</b> Select the source of the EBP referral	<input type="checkbox"/>	Child Youth-Family Support Center (CYFSC)	<input type="checkbox"/>	Family Advocate	<input type="checkbox"/>	Physician
	<input type="checkbox"/>	Community Natural Support	<input type="checkbox"/>	Foster Parent	<input type="checkbox"/>	Police
	<input type="checkbox"/>	Congregate Care Facility	<input type="checkbox"/>	Info-Line (211)	<input type="checkbox"/>	Probation/Court
	<input type="checkbox"/>	CTBHP/Insurer	<input type="checkbox"/>	Juvenile Probation / Court	<input type="checkbox"/>	Psychiatric Hospital
	<input type="checkbox"/>	DCF	<input type="checkbox"/>	Other Community Provider Agency	<input type="checkbox"/>	School
	<input type="checkbox"/>	Detention Involved	<input type="checkbox"/>	Other Program within Agency	<input type="checkbox"/>	Self/Family
	<input type="checkbox"/>	Emergency Department	<input type="checkbox"/>	Other State Agency		
<b>CBITS Assessment Outcome:</b> What was the outcome of the referral to the agency's EBP team? *	<input type="checkbox"/>	Assessment not completed	<input type="checkbox"/>	Not appropriate for selected EBP	<input type="checkbox"/>	No treatment needed
	<input type="checkbox"/>	Appropriate for selected EBP	<input type="checkbox"/>	Not appropriate for selected EBP but needs other treatment		
<b>CBITS Intake Date: !</b> Date of the EBP Intake						
<b>Treatment Information: School</b>						
During the 3 months prior to the start of CBITS treatment...						
<b>Child's school attendance: *</b>	<input type="checkbox"/>	Good (few or no days missed)	<input type="checkbox"/>	No School Attendance: Child Too Young for School	<input type="checkbox"/>	No School Attendance: Other
	<input type="checkbox"/>	Fair (several days missed)	<input type="checkbox"/>	No School Attendance: Child Suspended/Expelled from School		
	<input type="checkbox"/>	Poor (many days missed)	<input type="checkbox"/>	No School Attendance: Child Dropped Out of School		
<b>Suspended or expelled: *</b>			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<b>IEP: *</b> Does the child have an Individual Education Plan (special education)?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<b>Treatment Information: Legal</b>						
During the 3 months prior to the start of CBITS treatment...						
<b>Arrested: *</b> Has the child been arrested since start of treatment?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<b>Detained or incarcerated: *</b> Has the child been detained or incarcerated since start of treatment?			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<b>Treatment Information: Medical</b>						
During the 3 months prior to the start of CBITS treatment...						
<b>Alcohol and/or drugs problems: *</b>			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<b>Evaluated in ER/ED for psychiatric issues: *</b>			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<b>Certified medically complex: *</b>			<input type="checkbox"/>	Yes	<input type="checkbox"/>	No