Bounce Back Facesheets: Intake and Discharge

Instructions: Complete the following facesheets for each child. The intake facesheet should be completed once the child is added to a Bounce Back group. The discharge facesheet should be completed once the child ends the Bounce Back group and completes the Post Group Assessments.

Contents:

Child Health and Development Institute of Connecticut, Inc.

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

Clinician First and Last Name: !		**Child Group Assignment:**	
Provider Name: !		**Site Name: !**	

Child Information

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

Child Identification Codes

Please enter client identifiers below. Only **ONE** of them is required.

Agency-assigned Client ID Number (not PHI): !		**PSDCRS Client ID Number: !**	

Family Information

Caregiver 1 Relationship: *		**Caregiver 2 Relationship:**	
Preferred Language of Adult Participating in Treatment: *			

Does the adult participating in treatment speak English?	❒	Yes	❒	No

Primary Language of Child						
Family Composition: * Select the choice that best describes the composition of the family.	❒	Two parent family	❒	Single parent - biological/adoptive parent	❒	Relative/guardian
	❒	Single Parent with unrelated partner	❒	Blended Family	❒	Other
Living Situation of Child: * What is the child's living situation?	❒	College Dormitory	❒	Job Corps	❒	Psychiatric Hospital
	❒	Crisis Residence	❒	Medical Hospital	❒	Residential Treatment Facility
	❒	DCF Foster Home	❒	Mentor	❒	TFC Foster Home (privately licensed)
	❒	Group Home	❒	Military Housing	❒	Transitional Housing
	❒	Homeless/Shelter	❒	Other (specify):		
	❒	Jail/Correctional Facility	❒	Private Residence		

System Involvement

Child/Family involved with DCF? *			❒	Yes	❒	No
If child / family is involved with DCF, please complete ALL of the following questions:						
DCF Case ID:			**DCF Person Link ID:**			
DCF Status:	❒	Child Protective Services – In-Home	❒	Family with Service Needs – (FWSN) In-Home	❒	Not DCF – On Probation
	❒	Child Protective Services – Out of Home	❒	Family with Service Needs (FWSN) Out of Home	❒	Not DCF – Other Court Involved
	❒	Dual Commitment (JJ and Child Protective Services)	❒	Juvenile Justice (delinquency) commitment	❒	Termination of Parental Rights
	❒	Family Assessment Response	❒	Not DCF	❒	Voluntary Services Program
DCF Regional Office:						
Youth involved with Juvenile Justice (JJ) System? *			❒	Yes	❒	No

If youth is involved with JJ, please complete ALL of the following questions:						
CSSD Client ID:			**CSSD Case ID:**			
CSSD Case Type:			❒	Delinquency	❒	Family with Service Needs (Status Offense)
CSSD Case Status:	❒	Administrative Supervision	❒	Juvenile probation	❒	Restore Probation
	❒	Extended Probation	❒	Non-Judicial FWSN Family Service Agreement	❒	Suspended Order
	❒	Interim Orders	❒	Non-Judicial Supervision (NJS)	❒	Waived PDS - Probation
	❒	Judicial FWSN Supervision	❒	Non-Judicial Supervision Agreement		
Court District:						
Court Handling Decision:			❒	Judicial	❒	Non-Judicial
Specific Treatment Information						
What treatment model are you using with this child? *			❒	CBITS	❒	TF-CBT
			❒	MATCH-ADTC	❒	Bounce Back
First Bounce Back Clinical Session Date: * Date of first Bounce Back Group Session						
Treatment Information						
Agency Referral Date/Request for Service: * Date child was referred to agency			**Agency Intake Date: *** What is the intake date for the client at the agency?			
Bounce Back Referral Date: * Date the child was referred for Bounce Back services						
Bounce Back Referral Source: * Select the source of the Bounce Back referral	❒	Child Youth-Family Support Center (CYFSC)	❒	Family Advocate	❒	Physician
	❒	Community Natural Support	❒	Foster Parent	❒	Police
	❒	Congregate Care Facility	❒	Info-Line (211)	❒	Probation/Court
	❒	CTBHP/Insurer	❒	Juvenile Probation / Court	❒	Psychiatric Hospital
	❒	DCF	❒	Other Community Provider Agency	❒	School
	❒	Detention Involved	❒	Other Program within Agency	❒	Self/Family
	❒	Emergency Department	❒	Other State Agency		
Bounce Back Assessment Outcome: * What was the outcome of the referral to the agency's Bounce Back team?	❒	Assessment not completed	❒	Not appropriate for selected EBP	❒	No treatment needed
	❒	Appropriate for selected EBP	❒	Not appropriate for selected EBP but needs other treatment		
Bounce Back Intake Date: ! Date of the Bounce Back Intake						

Treatment Information: School

During the 3 months prior to the start of the Bounce Back treatment…

Child's school attendance: *	❒	Good (few or no days missed)	❒	No School Attendance: Child Too Young for School	❒	No School Attendance: Other
	❒	Fair (several days missed)	❒	No School Attendance: Child Suspended/Expelled from School		
	❒	Poor (many days missed)	❒	No School Attendance: Child Dropped Out of School		
Suspended or expelled: *			❒	Yes	❒	No
IEP: *Does the child have an Individual Education Plan (special education)?			❒	Yes	❒	No

Treatment Information: Legal

During the 3 months prior to the start of the Bounce Back treatment…

Arrested: * Has the child been arrested since start of treatment?	❒	Yes	❒	No
Detained or incarcerated: * Has the child been detained or incarcerated since start of treatment?	❒	Yes	❒	No

Treatment Information: Medical

During the 3 months prior to the start of Bounce Back treatment…

Alcohol and/or drugs problems: *	❒	Yes	❒	No
Evaluated in ER/ED for psychiatric issues: *	❒	Yes	❒	No
Certified medically complex: *	❒	Yes	❒	No
Primary Medical Complex Diagnosis:				

Client Face Sheet: Discharge

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Direct Service Provider User Information

Clinician First and Last Name: !		**Child Group Assignment:**	
Provider Name: !		**Site Name: !**	

Child Information

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

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Discharge Reason: *	❒	Successfully completed EBP model requirements - no more treatment needed	❒	Referred to higher level of care	❒	Referred for other non-EBP (outpatient) within agency
	❒	Successfully completed EBP model requirements - continue with other treatment	❒	Family moved out of area	❒	Other (specify)
	❒	Family discontinued treatment	❒	Referred to another agency		
	❒	Referred for other EBP (outpatient) within agency	❒	Assessment only - no treatment provided		

Family Information

Caregiver 1 Relationship: *		**Caregiver 2 Relationship:**			
Preferred Language of Adult Participating in Treatment: *					
Does the adult participating in treatment speak English?		❒	Yes	❒	No
Primary Language of Child					
Family Composition: * Select the choice that best describes the composition of the family.	❒ Two parent family	❒	Single parent - biological/adoptive parent	❒	Relative/guardian
	❒ Single Parent with unrelated partner	❒	Blended Family	❒	Other
Living Situation of Child: * What is the child's living situation?	❒ College Dormitory	❒	Job Corps	❒	Psychiatric Hospital
	❒ Crisis Residence	❒	Medical Hospital	❒	Residential Treatment Facility
	❒ DCF Foster Home	❒	Mentor	❒	TFC Foster Home (privately licensed)
	❒ Group Home	❒	Military Housing	❒	Transitional Housing
	❒ Homeless/Shelter	❒	Other (specify):		
	❒ Jail/Correctional Facility	❒	Private Residence		

System Involvement

Child/Family involved with DCF? *		❒	Yes	❒	No
If child / family is involved with DCF, please complete ALL of the following questions:					
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DCF Status:	❒ Child Protective Services – In-Home	❒	Family with Service Needs – (FWSN) In-Home	❒	Not DCF – On Probation
	❒ Child Protective Services – Out of Home	❒	Family with Service Needs (FWSN) Out of Home	❒	Not DCF – Other Court Involved
	❒ Dual Commitment (JJ and Child Protective Services)	❒	Juvenile Justice (delinquency) commitment	❒	Termination of Parental Rights
	❒ Family Assessment Response	❒	Not DCF	❒	Voluntary Services Program
DCF Regional Office:					
Youth involved with Juvenile Justice (JJ) System? *		❒	Yes	❒	No
If youth is involved with JJ, please complete ALL of the following questions:					
CSSD Client ID:		**CSSD Case ID:**			
CSSD Case Type:		❒	Delinquency	❒	Family with Service Needs (Status Offense)
CSSD Case Status:	❒ Administrative Supervision	❒	Juvenile probation	❒	Restore Probation
	❒ Extended Probation	❒	Non-Judicial FWSN Family Service Agreement	❒	Suspended Order
	❒ Interim Orders	❒	Non-Judicial Supervision (NJS)	❒	Waived PDS - Probation
	❒ Judicial FWSN Supervision	❒	Non-Judicial Supervision Agreement		
Court District:					

Court Handling Decision:	❒	Judicial	❒	Non-Judicial

Specific Treatment Information

What treatment model are you using with this child? *	❒	CBITS	❒	TF-CBT
	❒	MATCH-ADTC	❒	Bounce Back
First Bounce Back Clinical Session Date: * Date of first Bounce Back Group Session				

Treatment Information

Agency Referral Date/Request for Service: * Date child was referred to agency			**Agency Intake Date: *** What is the intake date for the client at the agency?			
Bounce Back Referral Date: * Date the child was referred for Bounce Back services						
Bounce Back Referral Source: * Select the source of the Bounce Back referral	❒	Child Youth-Family Support Center (CYFSC)	❒	Family Advocate	❒	Physician
	❒	Community Natural Support	❒	Foster Parent	❒	Police
	❒	Congregate Care Facility	❒	Info-Line (211)	❒	Probation/Court
	❒	CTBHP/Insurer	❒	Juvenile Probation / Court	❒	Psychiatric Hospital
	❒	DCF	❒	Other Community Provider Agency	❒	School
	❒	Detention Involved	❒	Other Program within Agency	❒	Self/Family
	❒	Emergency Department	❒	Other State Agency		
Bounce Back Assessment Outcome: * What was the outcome of the referral to the agency's Bounce Back team?			❒	Assessment not completed	❒	Not appropriate for selected EBP but needs other treatment
			❒	Appropriate for selected EBP	❒	No treatment needed
Bounce Back Intake Date: ! Date of the Bounce Back Intake			**Discharge Date: *** Date of the Bounce Back Discharge			

Treatment Information: School

Since the start of Bounce Back treatment…

Child's school attendance: *	❒	Good (few or no days missed)	❒	No School Attendance: Child Too Young for School	❒	No School Attendance: Other
	❒	Fair (several days missed)	❒	No School Attendance: Child Suspended/Expelled from School		
	❒	Poor (many days missed)	❒	No School Attendance: Child Dropped Out of School		
Suspended or expelled: *			❒	Yes	❒	No
IEP: * Does the child have an Individual Education Plan (special education)?			❒	Yes	❒	No

Treatment Information: Legal				
Since the start of Bounce Back treatment…				
Arrested: * Has the child been arrested since start of treatment?	❒	Yes	❒	No
Detained or incarcerated: * Has the child been detained or incarcerated since start of treatment?	❒	Yes	❒	No
Treatment Information: Medical				
Since the start of Bounce Back treatment …				
Alcohol and/or drugs problems: *	❒	Yes	❒	No
Evaluated in ER/ED for psychiatric issues: *	❒	Yes	❒	No
Certified medically complex: *	❒	Yes	❒	No
Primary Medical Complex Diagnosis:				