

Section 5

Attachments

- A. Proposal Application Checklist
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- F. Hawaii Child & Adolescent Service System Program (CASSP) Principles
- G. Evidence-Based Services Committee – Biennial Report – Summary of Effective Interventions for Youth with Behavioral and Emotional Needs. Fall 2007.
- H. CAMHD Credentialing and Recredentialing Policy & Procedures
- I. CAMHD Quality Assurance and Improvement Plan
- J. Quarterly Title IV-E Training Activities and Cost Reports
- K. MST Referral Form
- L. Monthly Treatment Progress Summary

Proposal Application Checklist

Applicant: _____

RFP No.: _____

The applicant's proposal must contain the following components in the order shown below. This checklist must be signed, dated and returned to the purchasing agency as part of the Proposal Application. SPOH forms are on the SPO website. See Section 1, paragraph II Website Reference.*

| Item | Reference in RFP | Format/Instructions Provided | Required by Purchasing Agency | Completed by Applicant |
|--|------------------|---|-------------------------------|------------------------|
| General: | | | | |
| Proposal Application Identification Form (SPO-H-200) | Section 1, RFP | SPO Website* | X | |
| Proposal Application Checklist | Section 1, RFP | Attachment A | X | |
| Table of Contents | Section 5, RFP | Section 5, RFP | X | |
| Proposal Application (SPO-H-200A) | Section 3, RFP | SPO Website* | X | |
| Tax Clearance Certificate (Form A-6) | Section 1, RFP | Dept. of Taxation Website (Link on SPO website)* | | |
| Cost Proposal (Budget) | | | | |
| SPO-H-205 | Section 3, RFP | SPO Website* | | |
| SPO-H-205A | Section 3, RFP | SPO Website* Special Instructions are in Section 5 | | |
| SPO-H-205B | Section 3, RFP, | SPO Website* Special Instructions are in Section 5 | | |
| SPO-H-206A | Section 3, RFP | SPO Website* | | |
| SPO-H-206B | Section 3, RFP | SPO Website* | | |
| SPO-H-206C | Section 3, RFP | SPO Website* | | |
| SPO-H-206D | Section 3, RFP | SPO Website* | | |
| SPO-H-206E | Section 3, RFP | SPO Website* | | |
| SPO-H-206F | Section 3, RFP | SPO Website* | | |
| SPO-H-206G | Section 3, RFP | SPO Website* | | |
| SPO-H-206H | Section 3, RFP | SPO Website* | | |
| SPO-H-206I | Section 3, RFP | SPO Website* | | |
| SPO-H-206J | Section 3, RFP | SPO Website* | | |
| Certifications: | | | | |
| Federal Certifications | | Section 5, RFP | | |
| Debarment & Suspension | | Section 5, RFP | | |
| Drug Free Workplace | | Section 5, RFP | | |
| Lobbying | | Section 5, RFP | | |
| Program Fraud Civil Remedies Act | | Section 5, RFP | | |
| Environmental Tobacco Smoke | | Section 5, RFP | | |
| Program Specific Requirements: | | | | |
| | | | | |
| | | | | |

Authorized Signature

Date

Sample

Proposal Application Table of Contents

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Attachment C

Interagency Performance Standards and Practice Guidelines

(Effective July 1, 2006)

(This document is available on the same website of this RFP. This document and subsequent updates will be available on the Department of Health, CAMHD website under Guiding Documents at

<http://www.hawaii.gov/health/mental-health/camhd/resources/index.html>)

Attachment D

State of Hawaii Coordinated Service Plan

Current School Program _____ DOB _____ Client Record _____ CSP Date _____
 Parent Name/Names _____ IDEA/504 _____
 CSP Facilitator _____ FGC Office _____
 CAFAS: _____ Date: _____ Achenbach Date: _____ CALOCUS: _____ Date: _____

Youth/Family/Community Strengths and Resources:

potential reinforcers

Current Situation: *Give pertinent information regarding child's age, grade, family composition, ethnicity, etc.*

Treatment:

Home:

School:

Community:

Dx:

Meds:

Other agency involvement:

| Desired Outcomes | Needs | Strength-Based Strategies/Interventions/Tasks | By Whom | 1Start Date | Targeted 2End |
|-------------------------|--------------|--|----------------|------------------------|--------------------------|
| | | | | | |

TEAM MEMBERS

Your signature denotes your attendance and participation in the development of this CSP only. If you have questions or concerns about the contents once you receive the finished plan from the MHCC (within 5 working days of the CSP meeting), please follow up directly with the MHCC.

| Printed Name | Signature | Date | Position/Agency | Phone | Fax |
|--------------|-----------|------|------------------------------------|-------|-----|
| | | | Client | | |
| | | | Mother | | |
| | | | Father | | |
| | | | Family Support | | |
| | | | Probation Officer | | |
| | | | GAL | | |
| | | | DOH/MHCC | | |
| | | | CC/TFH Parent | | |
| | | | DOH/Clinical Director | | |
| | | | DOE/SBBH and/or TLC Representative | | |
| | | | CC/Parent Consultant | | |
| | | | CC/Therapist | | |

Attachment E

Certifications

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about--
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace;
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--
 - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under-

signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

| | |
|---|----------------|
| SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL | TITLE |
| APPLICANT ORGANIZATION | DATE SUBMITTED |

Attachment F

Child and Adolescent Service System Program Principles

(CASSP Principles)

(This document is available on the same website of this RFP. This document and subsequent updates will be available on the Department of Health, CAMHD website under Guiding Documents at <http://www.hawaii.gov/health/mental-health/camhd/resources/index.html>)

Attachment G

Evidence-Based Services Committee Biennial Report

Summary of Effective Interventions for Youth with Behavioral and Emotional Needs.

Fall 2007.

(This document is available on the same website of this RFP. This document and subsequent updates will be available on the Department of Health, CAMHD website under Guiding Documents at

<http://www.hawaii.gov/health/mental-health/camhd/resources/index.html>)

Attachment H

CAMHD Credentialing and Recredentialing Policy & Procedures

(This document is available on the same website of this RFP. This document and subsequent updates will be available on the Department of Health, CAMHD website under Guiding Documents at

<http://www.hawaii.gov/health/mental-health/camhd/resources/index.html>)

Attachment I

CAMHD Quality Assurance and Improvement Plan

(This document is available on the same website of this RFP. This document and subsequent updates will be available on the Department of Health, CAMHD website under Guiding Documents at

<http://www.hawaii.gov/health/mental-health/camhd/resources/index.html>)

Attachment J

Quarterly Title IV-E Training Activities and Cost Report

Agency Name: _____

State Training Proportion of Total Trng. Cost [%]

CONTRACTED AGENCY QUARTERLY TRAINING REPORT (TRAINER & TRAINEE COSTS)

| Staff Name (Last, First) | Position Title | | Professional Degree (Ph.D., MSW, etc) | | Social Security or Position ID# | | | |
|--|---------------------------------|-----------------------|---------------------------------------|-----------------------|---------------------------------|-----------------------|------------------------|-------------------------|
| | | | | | | | | |
| Training Title/Topic and a Brief Description: | Trng. Purpose Categ***** | Training Dates | Training Modality* | Training Hours | Hourly Trng Cost** | Salary Cost*** | Other Costs**** | Total Trng. Cost |
| | | | | | | \$ - | | \$ - |
| | | | | | | \$ - | | \$ - |
| | | | | | | \$ - | | \$ - |
| | | | | | | \$ - | | \$ - |
| Total Training Hours/Cost for Staff | | | | 0 | | \$ - | \$ - | \$ - |

| Staff Name (Last, First) | Position Title | | Professional Degree (Ph.D., MSW, etc.) | | Social Security or Position ID# | | | |
|--|---------------------------------|-----------------------|--|-----------------------|---------------------------------|-----------------------|------------------------|-------------------------|
| | | | | | | | | |
| Training Title/Topic and a Brief Description: | Trng. Purpose Categ***** | Training Dates | Training Modality* | Training Hours | Hourly Trng Cost** | Salary Cost*** | Other Costs**** | Total Trng. Cost |
| | | | | | | \$ - | | \$ - |
| | | | | | | \$ - | | \$ - |
| | | | | | | \$ - | | \$ - |
| | | | | | | \$ - | | \$ - |
| Total Training Hours/Cost for Staff | | | | 0 | | \$ - | \$ - | \$ - |

INSTRUCTIONS: 1) Read Attachment before filling out this form;
 2) Use this form to list all training attended or conducted by staff.

IV-E Training Form_05

Attachment K

MST Referral Form

HOME-BASED MST REFERRAL PROCESS _____ Team

When a Care Coordinator or an MHS 1 identifies a case as a possible MST referral, the following steps should be followed:

1. Discuss MST services with care-giver, PO, and others on treatment team as necessary;
2. Complete all sections of the MST Referral form;
3. Attach a referral packet (to include most recent clinical evaluation, IEP/504MP, CSP, court documents);
4. **Fax this information to:** _____.

Bernie will then render a disposition (*approved, deferred pending further information, or denied*) and fax a signed copy of the referral form to the Care Coordinator and CAMHD within two (2) business days.

Upon receipt of an **approved referral form**, the Care Coordinator should await information from the MST therapist assigned to the case regarding the start date of treatment, and then promptly complete Service Authorizations for the TIFFE MST therapist. Service Authorization dates should begin on the date that the family consents to treatment.

Upon receipt of a **pending referral form**, the Care Coordinator should supply the requested additional information.

No action is necessary for a **denied referral form**.

Upon approval of referral the MST team has seventy-two (72) hours to have a "face-to-face" meeting with the family. If this is not possible (only due to the family's inability to meet), the MST Team must notify the Care Coordinator and/or MHS 1 of these circumstances.

At the point at which the MST Supervisor or Therapist meets with the family and obtains written Consent to Treatment, the case is opened and the "clock starts ticking" on the three (3) to five (5) month duration of the MST service.

Following the initial family meeting or as soon as possible, the MST Therapist meets/communicates with the Care Coordinator, appropriate Treatment Team members, and important members of the child's ecology to identify the most significant overarching goals that will determine the focus of the work. When possible it is preferable to have a Treatment Team Meeting to set the overarching goals.

Home-Based MST Referral Form
Team

Please complete the following and FAX to: _____

Date: _____ Referring Care Coordinator: _____
Family Guidance Center: _____ Phone # _____ Fax # _____ CR# _____

Youth's Name: _____ Youth's DOB: _____

Youth's Address: _____

Parent(s) Name(s): _____

Legal Guardian? ___yes ___no If not who?

Parent(s) Phone Number(s): home: _____

work: _____
cell/pgr: _____

other: _____

Youth's School: _____ Grade: _____

Brief reason for referral (**Behavior identified** - not diagnosis or hypothesis of need):

Please check to ensure all of the following apply prior to the referral:

- ___ Youth is a CAMHD client age 11 through 17.
- ___ Child is in out-of-home placement due to willful misconduct (Placement: _____
To Be Discharged On: _____)
- ___ Child is at imminent risk of out-of-home placement due to willful misconduct
- ___ Youth has a long-term "family-like" placement to return to (i.e., an adult caregiver who has a connection to the youth and who is willing to take on long-term parental role) Must live with this adult full time.
- ___ Has youth received MST Services previously? Dates: _____

Youth is **not**: ___ actively psychotic, ___ autistic, ___ a juvenile sex-offender WITHOUT other delinquent behaviors, or ___ actively homicidal/suicidal at this time

Yes No: Pending court charges, that may result in incarceration for >30 days. Describe: _____

Referral has been discussed with ___ MHS 1 ___ family ___ PO (if there is one) ___ others on treatment team?

Any team members wanting different level of care? (If so, suggest team meeting with MST representative prior to referral)

Please attach the following documents: ___ Psychological assessment with AXIS I-V diagnosis (in past 12 mos.)
___ Current IEP or 504 Plan
___ Current CSP Report

Do not write below this line _____
List of most recent services utilized

_____ has been reviewed and

- approved
- deferred pending further information:
- denied for MST services as of:

Date

MST Clinical Supervisor

Response within 2 days of request:

Yes No

Further Information Required regarding:

- Referral form incomplete
- Discharge date
- Family-like placement
- Other: _____

Attachment L

Monthly Treatment Progress Summary

SERVICE PROVIDER MONTHLY TREATMENT & PROGRESS SUMMARY
Child and Adolescent Mental Health Division (CAMHD)

Instructions: Please complete and electronically submit this form to CAMHD by the 5th working day of each month (summarizing the time period of 1st to the last day of the previous month). The information will be used in service review, monitoring, planning and coordination in accordance with CAMHD policies and standards. Mahalo!

| | | | |
|----------------------------|------------------------------|----------------------------|-------------------------------|
| Client Name: | | CR #: | DOB: |
| Month/Year of Services: | Eligibility Status: | | Level of Care (one per form): |
| Axis I Primary Diagnosis: | Axis I Secondary Diagnosis: | Axis I Tertiary Diagnosis: | |
| Axis II Primary Diagnosis: | Axis II Secondary Diagnosis: | | |

Service Format (circle all that apply):

Individual Group Parent Family Teacher Other: _____

Service Setting (circle all that apply):

Home School Community Out of Home Clinic/Office Other: _____

| | | | | | | | | | | | | | | | | | | | | |
|----------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| Service Dates: | | | | | | | | | | | | | | | | | | | | |
|----------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|

Targets Addressed This Month (number up to 10):

| | | | | |
|------------------------------------|-----------------------------------|-------------------------------------|--------------------------------|---------------------------------|
| Activity Involvement | Community Involvement | Hyperactivity | Positive Peer Interaction | Shyness |
| Academic Achievement | Contentment, Enjoyment, Happiness | Learning Disorder, Underachievement | Phobia/Fears | Sleep Disturbance |
| Adaptive Behavior/Living Skills | Depressed Mood | Low Self-Esteem | Positive Thinking/Attitude | Social Skills |
| Adjustment to Change | Eating, Feeding Problems | Mania | Pregnancy Education/Adjustment | Speech and Language Problems |
| Aggression | Empathy | Medical Regimen Adherence | Psychosis | Substance Use |
| Anger | Enuresis, Encopresis | Occupational Functioning/Stress | Runaway | Suicidality |
| Anxiety | Fire Setting | Oppositional/Non-Compliant Behavior | School Involvement | Traumatic Stress |
| Assertiveness | Gender Identity Problems | Peer Involvement | School Refusal/Truancy | Treatment Engagement |
| Attention Problems | Grief | Peer/Sibling Conflict | Self-Control | Willful Misconduct, Delinquency |
| Avoidance | Health Management | Personal Hygiene | Self-Injurious Behavior | Other: |
| Cognitive-Intellectual Functioning | Housing/Living Situation | Positive Family Functioning | Sexual Misconduct | Other: |

CR # _____ (please repeat the number here)

Progress Ratings This Month (check appropriate rating for any target numbers endorsed as targets):

| # | Deterioration < 0% | No Significant Changes 0%-10% | Minimal Improvement 11%-30% | Some Improvement 31%-50% | Moderate Improvement 51%-70% | Significant Improvement 71%-90% | Complete Improvement 91%-100% | Date (If Complete) |
|----|-----------------------|-------------------------------------|-----------------------------------|--------------------------------|------------------------------------|---------------------------------------|-------------------------------------|-----------------------|
| 1 | | | | | | | | |
| 2 | | | | | | | | |
| 3 | | | | | | | | |
| 4 | | | | | | | | |
| 5 | | | | | | | | |
| 6 | | | | | | | | |
| 7 | | | | | | | | |
| 8 | | | | | | | | |
| 9 | | | | | | | | |
| 10 | | | | | | | | |

Intervention Strategies Used This Month (check all that apply):

| | | | | |
|----------------------------|---|-----------------------------------|----------------------------------|--------------------------------|
| Activity Scheduling | Emotional Processing | Line of Sight Supervision | Personal Safety Skills | Stimulus or Antecedent Control |
| Assertiveness Training | Exposure | Maintenance or Relapse Prevention | Physical Exercise | Supportive Listening |
| Attending | Eye Movement, Tapping | Marital Therapy | Play Therapy | Tangible Rewards |
| Behavioral Contracting | Family Engagement | Medication/ Pharmacotherapy | Problem Solving | Therapist Praise/Rewards |
| Biofeedback, Neurofeedback | Family Therapy | Mentoring | Psychoeducation, Child | Thought Field Therapy |
| Care Coordination | Free Association | Milieu Therapy | Psychoeducation, Parent | Time Out |
| Catharsis | Functional Analysis | Mindfulness | Relationship or Rapport Building | Twelve-Step Program |
| Cognitive | Goal Setting | Modeling | Relaxation | Other: |
| Commands | Guided Imagery | Motivational Interviewing | Response Cost | Other: |
| Communication Skills | Hypnosis | Natural and Logical Consequences | Response Prevention | Other: |
| Crisis Management | Ignoring/Differential Reinforcement of Other Behavior | Parent Coping | Self-Monitoring | |
| Cultural Training | Individual Therapy for Caregiver | Parent/Teacher Monitoring | Self-Reward/ Self-Praise | |
| Discrete Trial Training | Insight Building | Parent/Teacher Praise | Skill Building | |
| Educational Support | Interpretation | Peer Pairing | Social Skills Training | |

CR # _____ (please repeat the number here)

| Psychiatric Medications (List All) | Total Daily Dose | Dose Schedule | Check if Change | Description of Change |
|------------------------------------|------------------|---------------|--------------------------|-----------------------|
| _____ | _____ | _____ | <input type="checkbox"/> | _____ |
| _____ | _____ | _____ | <input type="checkbox"/> | _____ |
| _____ | _____ | _____ | <input type="checkbox"/> | _____ |
| _____ | _____ | _____ | <input type="checkbox"/> | _____ |
| _____ | _____ | _____ | <input type="checkbox"/> | _____ |

Projected Discharge Date: _____ Check if Discharged During Current Month

IF YOUTH WAS DISCHARGED THIS MONTH, PLEASE COMPLETE ITEMS A & B:

A. Discharge Living Situation (check one):

- Home Foster Home Group Care Residential Treatment
 Institution/Hospital Jail/Correctional Facility Homeless/Shelter Other: _____

B. Reason(s) for Discharge (check all that apply):

- Success/Goals Met Insufficient Progress Family Relocation
 Runaway/Elopement Refuse/Withdraw Eligibility Change Other: _____

Outcome Measures: Optional. If you have any of the following data, please report the most recent scores:

| | | | |
|--|--------------------------------|-------------------------|-------|
| CAFAS (8 Scales): (1-School:) (2-Home:) (3-Community:) (4-Behavior Toward Others:) | Date: | | |
| (5-Moods/Emotions:) (6-Self-Harm:) (7-Substance:) (8-Thinking:) (Total:) | | | |
| CASII/CALOCUS (Total): | CASII/CALOCUS (Level of Care): | Date: | |
| CBCL (Total Problems T): | CBCL (Internalizing T): | CBCL (Externalizing T): | Date: |
| YSR (Total Problems T): | YSR (Internalizing T): | YSR (Externalizing T): | Date: |
| TRF (Total Problems T): | TRF (Internalizing T): | TRF (Externalizing T): | Date: |
| Arrested During Month? (Y/N): | School attendance (% of days): | | |

Comments/Suggestions (attach additional sheets if necessary):

| | |
|--------------------------------------|-------------------------------|
| Provider Agency & Island: _____ | Clinician Name and ID#: _____ |
| Provider Supervisor Signature: _____ | Clinician Signature: _____ |
| Submitted to CAMHD (date): _____ | Care Coordinator: _____ |