Children and Youth Behavioral Health

Pathways to Well-Being/Intensive Services Eligibility Assessment

Client Name: _____ **Program/Clinic Name:** _____

DOB: _____ **MRN:** _____

1. Is the youth under the age of 21? Y / N
2. Does the youth have full scope Medi-Cal? Y / N
3. Does the youth meet medical necessity? Y / N
   (If yes, see Assessment/Annual update ____ /____ /____ or Progress Note ____ /____ /____)

4. Is the youth currently **RECEVING** or **BEING CONSIDERED FOR** any of the following?

SERVICES/PLACEMENTS	YES	SERVICES/PLACEMENTS	YES
Special Ed, SUD, or other Health & Human Services		Probation or other Legal Systems	
Therapeutic Behavioral Services (TBS)		Wraparound/Full Service Partnership (FSP)	
Specialized Care Rate		RCL 10+ or FFA/STRTP	
Psychiatric hosp. and/or DC'd w/in 90 days		2 or more psych. hosp. w/in 12 months	
2 or more ER visits due to mental health w/in 6 months		2 or more placement changes for behavior w/in 24 months	
2 or more antipsychotic meds at same time over 3 months		Age 0-5 w/ more than 1 MH DX **OR** more than 1 psychotropic meds	
Age 6-11 w/ more than 2 MH DX **OR** more than 2 psychotropic meds		Age 12-17 w/ more than 3 MH DX **OR** more than 3 psychotropic meds	
Received SMHS **AND** homeless during prior 6 months		Intensive SMHS (In-Home Crisis, Crisis Residential Program, etc.)	

Note: The above criteria are guidelines only and should not be used as absolutes.

(YES) ← Does the youth have an open Child Welfare case? → (NO)

If 1, 2, & 3 are all **YES**, ***and*** the youth is receiving/being considered for any service(s) in 4, then the youth meets criteria for **Pathways to Well-Being (PWB).**

PATHWAYS to WELL-BEING*

☐ **YES** ☐ **NO**

Was the youth opened/accepted for mental health services? Y / N

Regardless of eligibility, [secure] email this form to:

- CFSPathway2WellBeing@ssa.ocgov.com

If 1, 2, & 3 are all **YES**, ***and*** the youth is receiving/being considered for any service(s) in 4, then the youth meets criteria for **Intensive Services (IS).**

INTENSIVE SERVICES*

☐ **YES** ☐ **NO**

***** If eligible for **PWB/IS**, clinician must update the **CARE PLAN** to authorize **ICC** and/or **IHBS** services.

Staff Name: _____ Phone: _____

Signature: _____ Date: _____