



**BestCare Treatment Services, Crook County**  
**Child and Family Behavioral Health Screening Request**  
 Fax: 541-447-1121 Phone: 541-323-5330

CHILD/YOUTH/YOUNG ADULT: \_\_\_\_\_ DOB: \_\_\_\_\_  
 PREFERRED GENDER/PRONOUN: \_\_\_\_\_ INDIVIDUAL'S PRIMARY LANGUAGE \_\_\_\_\_  
 PARENT'S PRIMARY LANGUAGE \_\_\_\_\_ PARENT/GUARDIAN NAME: \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_  
 HOME PHONE \_\_\_\_\_ ALT. PHONE \_\_\_\_\_

REASON FOR REQUEST or REFERRAL (Required. Please attach supporting data):

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**Requesting Screening for:**

- Intensive In-Home Behavioral Health Treatment (Age: 0-20)
- Young Adults in Transition (Age: 14-25)
- Wraparound (Age: 0-18)
- Unsure

**Other services youth is currently receiving (mark all that apply):**

- Individual Education Plan / 504
- Primary Care Provider: \_\_\_\_\_
- Medications (Provided by): \_\_\_\_\_
- Individual Counseling: \_\_\_\_\_

**Multiple System Involvement (please mark all that apply):**

- DHS (Department of Human Services; Child Welfare)
- Juvenile Community Justice / OYA
- Intellectual Development Disabilities
- Substance Abuse Treatment

**Insurance Type:**

- Oregon Health Plan
- DMAP
- Private Insurance
- No Insurance

**PERSON AND/OR AGENCY REQUESTING SCREENING (please print):**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

*(Person and/or agency requesting the screening is not responsible for the approval or denial of the referral, the outcome of the referral or any financial obligation.)*

**CONSENT FOR SCREENING**

No screening, evaluation, or assessment will be conducted without parent / client consent. Screening does not guarantee admission into services.

Parent/ Guardian complete for children 0 to 13 years of age / Client completes if 14 years or older

- I give my consent to conduct the above checked mental health screening.
- I do not give my consent to conduct the above checked screening.

Parent/Guardian SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Client SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**Intensive In-Home Behavioral Health Treatment (IIBHT) Criteria:**



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- \_\_\_\_\_ 1. Resides in Crook County
- \_\_\_\_\_ 2. Age 0-20
- \_\_\_\_\_ 3. 2 or more DSM-5 mental health diagnoses
- \_\_\_\_\_ 4. Child/youth at risk of out-of-home placement
- \_\_\_\_\_ 5. Child/youth transitioning back to home from out-of-home placement or residential level of care
- \_\_\_\_\_ 6. Functional impairments/impact on multiple life domains (school/home/community)
- \_\_\_\_\_ 7. Child/youth has Pacific Source Oregon Health Plan (OHP) or Comagine Open-Card Insurance

**Young Adults in Transition Criteria:**

- \_\_\_\_\_ 1. Individual has Oregon Health Plan insurance, does not have any form of insurance or has recently been hospitalized and exhausted private insurance resources.
- \_\_\_\_\_ 2. Individual is seeking mental health support as the primary reason for seeking services.
- \_\_\_\_\_ 3. Residency - The parents, guardian or primary care giver of eligible children and youth will live in Crook County.
- \_\_\_\_\_ 4. Age - Eligible youth will be from 14 through 25 years of age. Youth in need of mental health treatment- Eligible youth will be determined to have need of mental health treatment.
- \_\_\_\_\_ 5. Under supported youth: Youth that are involved with Juvenile Community Justice, Oregon Youth Authority, Department of Human Services, homeless youth and youth with minimal natural supports, youth aging out of foster-care
- \_\_\_\_\_ 6. Transition: Youth transitioning out of Wraparound or EASA programs. Youth who do not meet criteria for EASA

**Wraparound / Intensive Care Coordination Criteria:**

- \_\_\_\_\_ 1. Individual is a capitated member of Pacific Source Oregon Health Plan or has recently been hospitalized and does not have any form of insurance or has recently been hospitalized and has exhausted private insurance resources.
- \_\_\_\_\_ 2. Family is engaged and wants this level of care.
- \_\_\_\_\_ 3. Children and youth up to age 18 with two or more primary mental health diagnosis.
- \_\_\_\_\_ 4. Risk for out of home placement due to mental health (psychiatric residential, behavioral rehabilitation, commercially sexually exploited children's residential program)
- \_\_\_\_\_ 5. Two or more system involvement with one of the following: special education, juvenile justice, developmental disabilities services, child welfare, mental health
- \_\_\_\_\_ 6. A mental health disorder not likely to resolve in 6 months or less
- \_\_\_\_\_ 7. Previous mental health treatment has been unsuccessful
- \_\_\_\_\_ 8. Recent serious mental health episode (suicide attempt or ideation, rapid deterioration of functioning, recent hospitalization, homicidal ideation or actions)
- \_\_\_\_\_ 9. Families with multiple barriers to engagement and treatment and limited resources