Central Oregon Guide for Referring Youth to Behavioral Health Services

A systematic guide for school partners and families who are referring youth to a higher level of care.

CONTENTS

Available for use throughout Crook County, Deschutes County, Jefferson County, and The Confederated Tribes of Warm Springs

**All text in blue are hyperlinks which when clicked will take you directly to the website*

Revised April 2022

FREQUENTLY USED TERMS

Behavioral Health: The promotion of mental health, resilience and wellbeing; the treatment of mental disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities

BHC: Behavioral Health Clinician

CATS: Crisis and Transitions Services

CCM: Complex Care Management

CMHP: Community Mental Health Program

DCBH: Deschutes County Behavioral Health

EASA: Early Assessment and Support Alliance

ED: Emergency Department

GOBHI: Greater Oregon Behavioral Health

I/DD: Intellectual and Developmental Disabilities

IIBHT: Intensive In Home Behavioral Health Treatment, available throughout Central Oregon; offers intensive supports in the home and in the community.

Intercept: YouthVillages program offers intensive support, communication skills, and strengths based mental health interventions

IPH: Inpatient psychiatric hospital such as Unity Hospital and Providence Child and Adolescent Psychiatric Unit

IYS: Intensive Youth Services

LOC: Levels of Care

MCAT: Mobile Crisis Assessment Team

PCP: Primary Care Physician

PMHNP: Psychiatric Mental Health Nurse Practitioner

PRTS: Psychiatric Residential Treatment Services

ROI: Release of Information

SCIP: Secure Children's Inpatient Program, aka "The State Hospital"

SOC: System of Care

Trillium Family Services: Includes the Children's Farm Home for preteens and up, The Parry Center, and Sagebrush Partial Hospitalization Program

YAT: Young Adults in Transition

Revised April 2022

LEVEL OF CARE #1: PREVENTION SUPPORTS AND OUTPATIENT SERVICES

INDICATORS OF LEVEL *some or all may apply	SERVICE ELEMENT	RECOMMENDED SERVICES
▪ Youth does not meet the medical necessity acuity requirements for Sagebrush or PRTS. ▪ No recent history of hospitalization. ▪ Youth might be safely maintained and effectively treated at a less intensive level of care. ▪ Identified positive structure and supports ▪ Parent lack of engagement/ student refusal to participate. ▪ Primary diagnosis is I/DD or Autism and the youth has low verbal and processing skills. ▪ Unable to admit youth to Sagebrush due to the current milieu or staffing concerns.	**Treatment Suggestions**	1. Review and revise individual safety plan with behavioral health providers. 2. Have all care providers sign ROI's for collaboration. 3. Schedule a Care Coordination meeting with WRAP partners, PCP Clinic, PacificSource Case Management, and all other behavioral health providers involved in youth treatment plan. 4. Weekly or bi-weekly therapy with outpatient counselor. 5. Explore IIBHT options; if appropriate make referrals to BestCare or Youth Villages. 6. Discuss options for group therapy with DCBH or Brightways. 7. Look into Big Brothers/Big Sisters for community based mentor support. 8. Critical School Supports Including: ○ Increased counselor support, suicide screening and MCAT referral, Student Threat Assessment, Sexual Incident Response Team, Review the Behavior Intervention Plan (BIP).
	Frequency	1. Care Coordination meetings will happen at least once a week. 2. IIBHT provides a *minimum* of four services hours per week that will be provided in home or in the community. 3. Big Brothers/Big Sisters mentor could meet once a week.
	Medication/ Psychiatric Services	1. Consult with PCP to see if medical concerns are exacerbating behaviors/behavioral health issues, and recommend a behavioral health level of care. 2. Consider psychiatric services, PMHP. 3. Explore psychological testing or additional testing with Pedal Clinic, Mindsights (no prior authorization needed).
	Crisis Intervention	1. Crook County Behavioral Health Crisis Phone Lines: ○ BestCare Crisis Line: 541-323-5530. Press 2 after 5pm. 2. Lifeline 1-800-273-8255 3. Deschutes County Behavioral Health Crisis Phone Lines: ○ 541-322-7500 Option 9 4. Jefferson County Behavioral Health Crisis Phone Line: ○ BestCare Crisis Line: 541-475-6575. Press 2 after 5pm. 5. 21 and Younger: Call Youthline ○ 1-877-968-8491 or TEXT teen2teen to 839863 6. Consider reaching out to the Central Oregon Suicide Prevention Alliance if necessary.
	Family Supports	1. Seek funding options from community providers ○ Examples include activities, gas cards, sensory items ,etc., 2. If the youth is currently in foster care, consider a consult with ODHS for a Maple Star referral. 3. Contact the Central Oregon chapter of the National Alliance on Mental Illness for peer supports,

		system navigation assistance, and education resources. 4. Connect parent/guardian with a FAN advocate. 5. Consider reaching out to your local Oregon Department of Human Services for assistance accessing behavioral health resources. 6. Check to see if the parent/guardian needs to apply for the Oregon Health Plan. 7. Explore the Oregon Family Support Network for trainings and advocacy. 8. Safe+Strong is a mental health support line: 1-800-273-8255 9. Oregon Food Bank o Find local free groceries, meals, or produce: https://foodfinder.oregonfoodbank.org/ 10. Find assistance with utilities, rent, or childcare through NeighborImpact or 211info.org

LEVEL OF CARE #2: ACCEPTED TO PARTIAL HOSPITALIZATION (ALSO KNOWN AS DAY TREATMENT), WAITING FOR ADMISSION

INDICATORS OF LEVEL *some or all may apply	SERVICE ELEMENT	RECOMMENDED SERVICES
• Day treatment criteria has been met because: ○ Recent behavioral health assessment with an eligible DSM 5 diagnosis. ○ Youth is able to maintain in a program and can be reasonably expected to respond to therapeutic intervention. ○ Youth's functioning is compromised by a primary psychiatric illness and requires psychiatric care for evaluation and treatment. ○ Attempts to effectively treat the youth in a less restrictive level of care have failed or are not accessible. • Youth **does** meet the medical necessity acuity requirements for Sagebrush and has been accepted into the program; however, there is anticipated wait time of (X) amount of months or weeks before in person attendance begins. ○ Youth unable to maintain during transportation due to longer distance. ○ Current milieu: not able to add a student due to current needs/population, and/or staffing concerns.	**Treatment Suggestions**	1. Review and revise individual safety plan with behavioral health providers. 2. Schedule a Care Coordination meeting with WRAP partners, PCP Clinic, PacificSource Case Management, and all other behavioral health providers involved in youth treatment plan. 3. ROI's signed to increase collaboration between providers. 4. Explore IIBHT options through YouthVillages or BestCare 5. Look into individual and family therapy twice a week or more. 6. Look into Big Brothers/Big Sisters, Friends of the Children, COPY Program for youth with incarcerated parents. 7. Explore Cascade Youth and Families programs. 8. Consider a full physical exam and dental care to rule out physical causes, reasons for acting out behaviors. 9. Critical School Supports Including: ○ Increased counselor support, suicide screening and MCAT referral, Student Threat Assessment, Sexual Incident Response Team, Review the Behavior Intervention Plan (BIP)
	Frequency	1. Care Coordination meetings will happen at cadence set forth by providers. 2. IIBHT provides a *minimum* of four service hours per week to be provided in home or the community. 3. Individual therapy and family therapy cadence to be set by provider. 4. Peer support/Mentorship programs shall follow agency guidelines.
	Medication/ Psychiatric Services	1. Consult with PCP/ Consult with psychiatry. 2. Explore psychological testing or additional testing with Pedal Clinic, Mindsights (no prior authorization needed).
	Crisis Intervention	1. Crook County Behavioral health Crisis Phone Lines: ○ BestCare Crisis Line: 541-323-5530. Press 2 after 5pm. 2. Deschutes County Behavioral health Crisis Phone Lines and MCAT Referrals for schools and families ○ 541-322-7500 Option 9 3. Jefferson County Behavioral health Crisis Phone Line: ○ BestCare Crisis Line: 541-475-6575. Press 2 after 5pm. 4. Explore supports offered by YouthEra ○ Includes: Virtual Support, Crisis Intervention, Drop-In Centers 5. 21 and Younger: Call Youthline

LEVEL OF CARE #2: ACCEPTED TO PARTIAL HOSPITALIZATION (ALSO KNOWN AS DAY TREATMENT), WAITING FOR ADMISSION

		○ 1-877-968-8491 or TEXT teen2teen to 839863 6. Lifeline 1-800-273-8255 7. Consider reaching out to the Central Oregon Suicide Prevention Alliance if necessary. ***Please note that Sagebrush 24 hour crisis services are provided to youth once in person attendance has begun. **
	Family Supports	1. Explore respite care options: ○ Family member, Kindred Connections, GOBHI 2. Seek funding options from community providers. ○ Examples include activities, gas cards, sensory items, etc., 3. Connect parent/guardian with a FAN advocate. 4. If the youth is currently in foster care, consider a consult with ODHS for a Maple Star referral. 5. Consider reaching out to your local Oregon Department of Human Services for assistance accessing behavioral health resources. 6. Explore the Oregon Family Support Network for trainings and advocacy. 7. Safe+Strong Helpline provides physical, mental, and community supports 1-800-273-8255 8. Oregon Food Bank ○ Find local free groceries, meals, or produce: https://foodfinder.oregonfoodbank.org/ 9. Find assistance with utilities, rent, or childcare through NeighborImpact or 211info.org

LEVEL OF CARE #3: ACUITY LEVELS EXCEED OUTPATIENT PROGRAM STANDARDS; HIGHER LEVEL OF CARE OR RESIDENTIAL SERVICES NEEDED

INDICATORS OF LEVEL *some or all may apply	SERVICE ELEMENT	RECOMMENDED SERVICES
▪ Youth exceeds medical necessity acuity requirements for Sagebrush, and a referral is recommended for a higher level of care. ▪ There is a substantial wait time before youth will be admitted to the higher level of care. ▪ Primary diagnosis is related to eating disorders. ▪ History of hospitalization within the last 4 months. ▪ Serious potential to harm self/others. ▪ Recent suicidal/ homicidal ideation. ▪ Limited supports available ▪ In danger of losing placement (school, home, or foster care placement).	**Treatment Suggestions**	1. Referral to higher levels of care including PRTS, Mental Health Sub Acute, Stabilization Center, Emergency Department, In-Patient Psychiatric Hospital 2. Review and revise individual safety plan with behavioral health providers. 3. Schedule a Care Coordination meeting with WRAP partners, PCP Clinic, PacificSource Case Management, and all other behavioral health providers involved in youth treatment plan. 4. Consider Rimrock Trails residential SUD treatment services program. 5. Explore scheduling a consult with Rimrock Trails Eating Disorder specialist. 6. ROI's signed to increase collaboration between providers. 7. Referral to PacificSource Case Management: Jessica.Spencer@pacificsource.com 8. Explore IIBHT options through YouthVillages or BestCare 9. Look into individual and family therapy twice a week or more. 10. Consider a full physical exam and dental care to rule out physical causes, reasons for acting out behaviors. 11. Critical School Supports Including: ○ Increased counselor support, suicide screening and MCAT referral, Student Threat Assessment, Sexual Incident Response Team, Review the Behavior Intervention Plan (BIP) . 12. Increase I/DD services if eligible ○ This includes: addition of Personal Support Worker and revised family behavior plan.
	Frequency	1. IIBHT provides a *minimum* of four service hours per week to be completed in home or the community. 2. Individual therapy and family therapy cadence to be set by provider.
	Medication/ Psychiatric Services	1. Consult with PCP/ Consult with psychiatry 2. Explore psychological testing or additional testing with Pedal Clinic, Mindsights (no prior authorization needed).
	Crisis Intervention	1. Revise and review safety plan with care management team every three days. 2. Consider reaching out to the Central Oregon Suicide Prevention Alliance if necessary. 3. Explore supports provided by YouthEra ○ Includes: Virtual Support, Crisis Intervention, Drop-In programs 4. Lifeline 1-800-273-8255 5. Crook County Mental Health Crisis Phone Lines: ○ BestCare Crisis Line: 541-323-5530. Press 2 after 5pm. 6. Deschutes County Mental Health Crisis Phone Lines for MCAT services: ○ 541-322-7500 Option 9

LEVEL OF CARE #3: ACUITY LEVELS EXCEED OUTPATIENT PROGRAM STANDARDS; HIGHER LEVEL OF CARE OR RESIDENTIAL SERVICES NEEDED

▪ Co-occurring substance use disorders. ▪ I/DD diagnosis		7. Jefferson County Mental Health Crisis Phone Line: ○ BestCare Crisis Line: 541-475-6575. Press 2 after 5pm. 8. 21 and Younger: Call Youthline ○ 1-877-968-8491 or TEXT teen2teen to 839863
	Family Supports	1. Explore respite care options including GOBHI, DHS, Cascade Youth and Family Services, Kindred Connections 2. Contact the Central Oregon chapter of the National Alliance on Mental Illness for peer supports, system navigation assistance, and education resources. 3. Explore the Oregon Family Support Network for trainings and advocacy. 4. Connect parent/guardian with Family Resource Center of Central Oregon to participate in support groups. https://frconline.org/news-events/ 5. Connect parent/guardian with a FAN advocate 6. Safe+Strong Helpline provides emotional, mental, and community supports 1-800-273-8255 7. Oregon Food Bank ○ Find local free groceries, meals, or produce: https://foodfinder.oregonfoodbank.org/ 8. Find assistance with utilities, rent, or childcare through NeighborImpact or 211info.org

RIMROCK TRAILS
TREATMENT SERVICES

Do you or someone you love need support? Let our team help!

- Adult, Teen, Child and Family Mental Health Counseling
- Telehealth and Telepsychiatry
- Substance use Counseling
- Medication Management
- Eating Disorder Counseling Services

We serve Bend, Redmond and Prineville

Bend Counseling Clinic
548 SW 13th St.
Bend, OR 97702
(541) 388-8459

Redmond Counseling Clinic
215 SW 7th Street
Redmond, OR 97756
(541) 388-8459

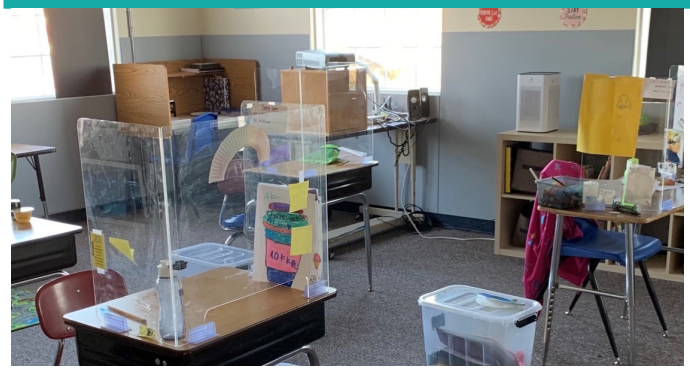
Prineville Counseling Clinic
446 NW 3rd St, Ste 104
Prineville, OR 97754
(541) 388-8459

Start the road to healing, connection, and hope by contacting our Behavioral Health Coordinator at (541) 388-8459 or visit our website at www.rimrocktrails.org.

Sagebrush Day Treatment Program

'We were impressed by our family's access to the full range of psychiatrists, therapists and trained care providers while our son was continuing his school work." - Day Treatment Parent

What is Day Treatment



Trillium's Day Treatment is a partial hospitalization level, mental health program provided in a school setting and schedule, with a focus on treatment including individual and family therapy, medication management, and skills groups. Trained staff support children throughout the school day and remain with them in the classroom to provide support. Classes are led by teachers from a local school district, and children are encouraged to complete school work in addition to their therapeutic activities. All services are clinically directed by a Child & Family Therapist and supported by mental health treatment staff.

Who We Are

We are a multi-disciplinary team of psychiatrists, therapists, and mental health treatment staff working with clients and families to help them understand how to manage their mental health needs.

Who We Serve

Building Brighter Futures with Children and Families

www.TrilliumFamily.org | info@TrilliumFamily.org | For Referrals Contact Our Access Dept. 1.888.333.6177

How We Measure Success

Each child is given in Individualized Plan of Care, which outlines areas of focus in treatment as well as long- and short-term goals to measure client's progress in treatment. Goals are reviewed in a formal meeting to discuss and review treatment progress and potential discharge from Day Treatment. When treatment goals are met, children graduate from the Day Treatment program with a transition plan, including aftercare appointments with a medication provider, individual and family therapist, and school/classroom placement. Depending on their needs, clients may also discharge with the additional resources of group therapy, skills training, intensive outpatient services, and referrals to a primary care physician.

Transition

A full-time school Transition Specialist collaborates with the local school districts to ensure successful transitions back to a client's home school.

How Is It Funded

Clients are funded either by their family's private insurance coverage or by Oregon Health Plan (OHP).

Building Brighter Futures with Children and Families

www.TrilliumFamily.org | info@TrilliumFamily.org | For Referrals Contact Our Access Dept. 1.888.333.6177

Intercept

Serving Deschutes, Jefferson, and Crook counties; Youth ages 0-17

Insurance: OHP or Pacific Source Commercial

Services Provided: In Home Family and Individual Therapy, 24/7 Crisis Support, Psychiatry Services; Meeting in home for services 3x weekly for 4-6 months

Focus on stabilizing behaviors in the home, supporting with safety planning in the home, developing or enhancing parenting skills, developing and practicing coping skills, trauma therapy

Ways to Refer: Option 1: Refer a Child - Youth Villages; Option 2: Email referral form to YVOregonPlacement@youthvillages.org or fax referral form to 503-675-2258 or call (503) 675-2246

IIBHT (Intensive In Home Behavioral Health Treatment)

Serving Deschutes, Jefferson, and Crook counties; Youth ages 0-17

Insurance: OHP, Pacific Source Commercial, or Open Card

Services Provided: Individual and Family Therapy, Psychiatry Services, Youth Peer Support, Family Peer Support, 24/7 Crisis Support, Safety Planning Support. Families receive a minimum of 4 hours of services per week for 4-6 months

Focus on stabilizing behaviors in the home, safety planning in the home, developing or enhancing parenting skills, developing and practicing coping skills, trauma therapy

Ways to Refer: Option 1: Refer a Child - Youth Villages; Option 2: Email referral form to YVOregonPlacement@youthvillages.org or fax referral form to 503-675-2258 or call (503) 675-2246

Crisis and Transition Services (CATS)

Serving Deschutes County residents; Youth ages 0-18

CATS is an insurance blind program serving youth experiencing a mental or behavioral health crisis

Services Provided: Safety Planning, Individual and Family Therapy, Case Management, Referral Support, 24/7 Crisis Support, Family Peer Support, Psychiatry; meeting as frequently as needed for 14-45 days.

Ways to Refer: At this time, referrals are only accepted by Bend and Redmond St. Charles Hospitals, Deschutes County Stabilization Center, and MCAT. If you have a youth in crisis who would benefit from CATS, please refer to the Stabilization Center for assessment and referral. Assessments and intake can occur same day as the referral and are held in person at the Hospital or Stabilization Center.

For any questions involving current or previous CATS clients or potential referrals, please contact our 8am-5pm CATS phone line at 541-516-6334

Youth VILLAGES®
The force for families

Date of referral

Click here to submit

In-home Services Referral Form

Choose Program: Intercept ☐ IIBHT ☐ Unsure ☐

Child's Name	Ethnicity -Choose one-	DOB	SSN (if known)
Languages spoken	Preferred Language	Child's Gender	
Parent/Guardian:	Phone Number	Alternate Contact	
Address			
Referral Source Name		Agency	
Email		Phone Number(s)	

Date family was informed about Intercept Services:

Referral Behaviors (check all that apply):

- ☐ **Suicidal/Homicidal/Psychotic behaviors**
- ☐ **Physical Aggression**
- ☐ **Problem Sexual Behaviors**
- ☐ **Active Partner Violence**
- ☐ **Runaway behaviors**
- ☐ **Caregiver/Family Substance Abuse**
- ☐ **Risk of Out-of-Home Placment/Reunificaion Goal**
- ☐ **Family conflict**
- ☐ **Active Sexual Abuse**
- ☐ **Risk of Out-of-Home Placement**
- ☐ **Youth Substance Use**
- ☐ **Juvenile Justice Involvement**
- ☐ **Physical Abuse/Neglect (within past 6 months)**
- ☐ **Autism or Pervasive Developmental Delay**

Additional information not listed above concerning important events, risk and/or protective factors:

Please fax form with most recent clinical documentation to the Placement Department at
(503) 675-2258 or email to YVOregonPlacement@youthvillages.org
Feel free to call with any questions at 503-675-2246 or 1-888-98ACCESS (1-888-982-2237)

Click here to submit

DESCHUTES COUNTY HEALTH SERVICES

INTENSIVE YOUTH SERVICES BEHAVIORAL HEALTH SCREENING REQUEST

Email to: intensiveyouthservices@deschutes.org Fax: 541-617-4793 Phone: 541-213-6851

Name of referred: Click or tap here to enter text. **Date of Birth:** Click or tap to enter a date. **Gender:** Choose an item.

Pronouns: Choose an item. **Primary Language:** Choose an item. **Parent/Guardian Name:** Click or tap here to enter text.

Address: Click or tap here to enter text. **City:** Choose an item. **Phone:** Click or tap here to enter text.

Reason for Request: Click or tap here to enter text.

Requesting Screening for:

☐ Early Assessment and Support Alliance (Ages: 12-27)

☐ Young Adults in Transition – YAT (Ages: 14-24)

☐ Wraparound – WRAP (Ages: 0-18)

☐ Parent Child Interaction Therapy – PCIT (Ages: 2-6)

☐ Generation Parent Management Training – GenPMTO (Ages 7-17)

☐ KIDS Center Referral to DCBH (Ages 0-17 - Please include collateral)

Multiple System Involvement (please mark all that apply):

☐ DHS

☐ Juvenile Community Justice / OYA / Probation/Parole

☐ Intellectual Developmental Disabilities

☐ Substance Use Treatment (Rimrock/Best Care/Pfeiffer)

Other services (mark all that apply):

☐ Individual Education Plan / 504

☐ Primary Care Provider: Click or tap here to enter text.

☐ Medication (Provided by): Click or tap here to enter text.

☐ Individual Therapy (Provided by): Click or tap here to enter text.

☐ Youth Villages / Intercept: Click or tap here to enter text.

Insurance Type:

☐ Oregon Health Plan – Pacific Source

☐ Oregon Health Plan – Fee for Service

☐ Private Insurance

☐ No Insurance

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

Name: Click or tap here to enter text. Phone Number: Click or tap here to enter text. Date: Click or tap to enter a 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 financialobligation.)

CONSENT FOR SCREENING

Screening, evaluation, or assessment requires 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**_____

Authorization to exchange information (attached)

EASA Criteria. Must meet all of the following requirements:

DESCHUTES COUNTY HEALTH SERVICES

INTENSIVE YOUTH SERVICES BEHAVIORAL HEALTH SCREENING REQUEST

Email to: intensiveyouthservices@deschutes.org Fax: 541-617-4793 Phone: 541-213-6851

☐ Resides in Deschutes, Jefferson or Crook County
☐ Age 12-27 with an IQ over 70 or not already receiving developmental disability services
☐ No more than 12 months since diagnosed with a major psychotic disorder, if applicable
☐Psychotic symptoms are not known to be caused by the temporary or chronic effects of substance abuse or a known medical condition.
☐The person has experienced a significant decline in either academic, vocational, social or personal (sleep, hygiene) functioning.

And must meet one of the below:

☐The individual has experienced significant worsening or new symptoms in one or more of the following areas *in the last year:*

a. Thought disorganization as evidenced by disorganized speech and or/ writing. (Examples: confused conversations, not making sense, never getting to a point, unintelligible).
b. Behaviors, speech or beliefs are uncharacteristic and/or bizarre.
c. Complains of hearing voices or sounds that others do not hear.
d. The individual feels that other people are putting thoughts in their head, stealing their thoughts, believes others can read their mind (or vice versa), and/or hear their own thoughts out loud.
f. Episodes of depersonalization (Example: They believe that they do not exist or that their surroundings are not real).
g. Heightened sensitivities (lights, sounds etc.) and/or is experiencing visual distortions
h. Increased fear, anxiety or paranoia for no apparent reason or for an unfounded reason.

OR

☐Family history of a 1st degree relative (sibling or parent) with a major psychotic disorder

Young Adults in Transition Criteria

☐ Resides in Deschutes County
☐ Individual has Oregon Health Plan insurance, some private insurance or does not have any form of insurance
☐ Individual is seeking mental health support as the primary reason for seeking services.
☐ Age - Eligible youth will be from 14 through 24 years of age. Youth in need of mental health treatment- Eligible youth will be determined to have need of mental health treatment.
☐ Under supported youth: Youth that are involved with Juvenile Community Justice, Oregon Youth Authority, Department of Human Services, homeless youth and youth will minimal natural supports.
☐ Transition: Youth transitioning out of Wraparound or EASA programs. Individuals who do not meet criteria for EASA.

Wraparound / Intensive Care Coordination Criteria

☐Resides in Deschutes County
☐Individual is a capitated member of Pacific Source Oregon Health Plan or Oregon Health Plan Open Card
☐ Family is engaged and wants this level of care.
☐ Children and youth up to age 18 with two or more primary mental health diagnosis.
☐Risk for out of home placement due to mental health (psychiatric residential, behavioral rehabilitation, commercially sexually exploited children's residential program)
☐ Two or more system involvement with one of the following; special education, juvenile justice, developmental disabilities services, child welfare, mental health
☐A mental health disorder not likely to resolve in 6 months or less or previous mental health treatment has been unsuccessful
☐ Recent serious mental health episode (suicide attempt or ideation, rapid deterioration of functioning, recent hospitalization, homicidal ideation or actions)

Parent Child Interaction Therapy (PCIT) & Generation Parent Management Training (GEN-PMTO)

☐Resides in Deschutes County
☐ Family is engaged and wants this level of care.
☐ Children ages 2-6 PCIT
☐ Children ages 7-17 Gen-PMTO

Servicios de Salud del Condado de Deschutes

Petición para Evaluación de Salud Conductual de Servicios Intensivos para Jóvenes

Mande el correo electrónico a: intensiveyouthservices@deschutes.org Fax: (541) -617-4793 Número de teléfono: (541) -213-6851

Niño/Joven/Adulto Joven:_____Fecha de Nacimiento: _____

Género/pronombre preferido:_____ Idioma primario del individuo:

Idioma primario de los padres:

Nombre del /padres/tutor:_____

Dirección Ciudad Código postal

Número de casa Número teléfono alternativo: _____

Motivo de solicitud o referencia (Requerido Por favor agregue la información complementaria):

_____

_____

Solicitando una evaluación para:

- ☐ Evaluación temprana y Apoyo de Alianza (edad: 12-27)
- ☐ Adultos jóvenes en transición (edad: 14-25)
- ☐ Wraparound (edad: 0-18)
- ☐ No estoy seguro

Otros servicios que el joven está recibiendo actualmente (marque todos los que aplican):

- ☐ Plan Individual de Educación / 504
- ☐ Médico de Cuidado Primario _____
- ☐ Medicamentos (proveídos por):_____
- ☐ Consejería Individual:_____

Participación de múltiples sistemas (por favor marque todos los que aplican):

- ☐ DHS (Departamento de Servicios Humanos; Bienestar del Niño)
- ☐ Comunidad Juvenil de Justicia / OYA
- ☐ Desarrollo de Discapacidades Intelectuales
- ☐ Tratamiento de Abuso de Sustancias

Tipo de seguro médico:

- ☐ Plan del Seguro Médico
- ☐ DMAP tarifa del Seguro Médico
- ☐ Seguro Médico Privado
- ☐ No tiene seguro médico

Persona y/o agencia solicitando la evaluación (por favor use letra de molde):

Nombre:_____ Número telefónico:_____

Firma__ _ _Fecha___

(La persona o agencia solicitando la evaluación no es responsable por la aprobación o negación de la referencia, el resultado de la referencia o cualquier obligación financiera.)

Consentimiento para una evaluación

No se realizarán exámenes, valoraciones o evaluaciones sin el consentimiento de los padres/clientes. La evaluación no garantiza la admisión a los servicios.

Padres/Tutores llenarlo para niños de 0 a 13 años de edad/ el cliente lo llena si tiene 14 años o más

- ☐ Yo doy mi consentimiento para realizar la evaluación de salud mental marcada anteriormente.

Yo NO doy mi consentimiento para realizar la evaluación marcada anteriormente.

Padre/Guardián FRIMA_ _ _ **FECHA_**

FIRMA de cliente_ _ **_ FECHA_**

_____

Autorización para intercambiar información (adjunta)

Servicios de Salud del Condado de Deschutes

Petición para Evaluación de Salud Conductual de Servicios Intensivos para Jóvenes

Mande el correo electrónico a: intensiveyouthservices@deschutes.org Fax: (541) -617-4793 Número de teléfono: (541) -213-6851

Criterio EASA. Debe cumplir todos los siguientes requerimientos:

_____1. Reside en los condados de Deschutes, Jefferson o Crook County
_____2. (Edad) 12-27
_____3. Su coeficiente intelectual debe estar arriba de 70 y aún no está recibiendo servicios de discapacidad del desarrollo.
_____4. No más de 12 meses desde que fue diagnosticado con un trastorno psicótico mayor, si aplica
_____5. No se sabe que los síntomas psicóticos sean causados por los efectos temporales o crónicos del abuso de sustancias o una condición médica conocida.
_____6. La persona ha experimentado una decadencia ya sea en lo académico, vocacional, social o en lo personal (sueño, higiene) funcionamiento.

Y debe cumplir con 7 u 8 de los requisitos de abajo:

_____7. El individuo ha experimentado un empeoramiento significativo o nuevos síntomas en una o más de las siguientes áreas en el último año:

a. Desorganización en el pensamiento, como evidencia la desorganización del habla y/o escritura. (Ejemplos: conversaciones confusas, no hace sentido, nunca llega al punto, ininteligible).
b. Los comportamientos, el habla o las creencias son poco característicos y/o extraños.
c. Se queja de escuchar voces o sonidos que los demás no escuchan.
d. El individuo siente que las demás personas le están metiendo pensamientos en su cabeza, robando sus pensamientos, creen que otros pueden leer su mente (o viceversa), y/o escuchan sus propios pensamientos en voz alta.
e. Episodios de despersonalización (Ejemplo: Ellos creen que no existen o que su entorno no es real).
f. Sensibilidades agudizadas (luces, ruido, etc.) y/o está experimentando distorsiones visuales.
g. Aumento del miedo, la ansiedad o la paranoia sin razón aparente o por una razón infundada.

OR _____ 8. Antecedentes familiares, de un familiar de 1er grado (hermano o padre) con un trastorno psicótico mayor.

Adultos jóvenes en transición criterio

_____1. El individuo tiene el Plan de Salud de Oregón, no tiene ningún tipo de seguro médico o recientemente ha sido hospitalizado y ha agotado los recursos del seguro médico privado.
_____2. El individuo busca apoyo de salud mental como la razón principal para buscar servicios.
_____3. Residencia- los padres, tutores o cuidadores primarios de niños y jóvenes elegibles vivirán en el condado de Deschutes
_____4. Edad- los jóvenes elegibles tendrán entre 14 y 25 años de edad. Jóvenes con la necesidad de tratamiento de salud mental- Se determinará que los jóvenes elegibles necesitan tratamiento de salud mental.
_____5. Jóvenes con falta de apoyo: Jóvenes que están involucrados con la Justicia Juvenil de la Comunidad, la Autoridad de Jóvenes de Oregón, el Departamento de Servicios Humanos, jóvenes sin hogar y jóvenes con apoyos naturales mínimos.
_____6. Transición: jóvenes en transición de programas Wraparound o EASA. Los jóvenes que no cumplen con los criterios para EASA

Wraparound / Criterio de Coordinación del Cuidado Intensivo

_____1. El individuo tiene el Plan de Salud de Oregón, no tiene ningún tipo de seguro médico o recientemente ha sido hospitalizado y ha agotado los recursos del seguro médico privado.
_____2. La familia está comprometida y quiere este nivel de atención.
_____3. Niños y jóvenes hasta la edad de 18 años con dos o más diagnósticos primarios de salud mental.
_____4. Riesgo de colocación fuera del hogar debido a la salud mental (residencia psiquiátrica, rehabilitación conductual, programa residencial infantil para niños explotados sexualmente de manera comercial)
_____5. Dos o más implicaciones del sistema con uno de los siguientes; educación especial, justicia juvenil, servicios de discapacidad del desarrollo, bienestar del niño, salud mental.
_____6. Un trastorno de salud mental que probablemente no se resuelva en 6 meses o menos.
_____7. El tratamiento de salud mental previo no fue exitoso.
_____8. Un episodio grave de salud mental reciente (intento de suicidio o ideas de suicidio, deterioro rápido del funcionamiento, hospitalización reciente, ideas de homicidio o acciones).
_____9. Familias con múltiples barreras para participar, tratamiento y recursos limitados.

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):

_____

_____

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:

BestCare Treatment Services, Crook County

Child and Family Behavioral Health Screening Request

Fax: 541-447-1121 Phone: 541-323-5330

_____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

THIS GUIDE BROUGHT TO YOU BY:

High Desert Education Service District

Crook County Schools
where students dream, learn, & succeed

Est. 1883
BEND LAPINE
Schools
EDUCATING THRIVING CITIZENS

PacificSource Community Solutions

Trillium FAMILY SERVICES℠

DHS Oregon Department of Human Services

BestCare

Revised April 2022