



STATE OF MISSOURI
DEPARTMENT OF MENTAL HEALTH
CPS CHILD/YOUTH STATUS REPORT

PART I: This portion is to be completed by Mental Health/Case worker.

STAFF NAME (PRINT CLEARLY FIRST AND LAST NAME)	REPORTING MONTH/YEAR
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AGENCY CODE	AGENCY SITE (OPTIONAL)
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<input type="checkbox"/> Regular Data Collection <input type="checkbox"/> SOC or DFS Level 4 Data Collection	IF APPLICABLE, DATE CHILD/YOUTH BEGAN SOC/ DFS LEVEL 4	CHECK ALL THAT APPLY <input type="checkbox"/> SOC <input type="checkbox"/> DFS LEVEL 4
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ASSESSMENT TYPE <input type="checkbox"/> ADMISSION <input type="checkbox"/> REVIEW <input type="checkbox"/> DISCHARGE	DOES THIS CHILD MEET SED CRITERIA? <input type="checkbox"/> YES <input type="checkbox"/> NO ACUTE CRITERIA? <input type="checkbox"/> YES <input type="checkbox"/> NO FORENSIC? <input type="checkbox"/> YES <input type="checkbox"/> NO OTHER? _____	CHILD/YOUTH NAME SSN STATE ID DATE OF BIRTH (MM/DD/YY)
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Indicate services the child is **CURRENTLY** receiving, as well as services provided but discontinued by your Agency **IN THE LAST 6 MONTHS** or **past month** if **Review for SOC/DFS Level 4**. (Check all that apply)

CURRENTLY RECEIVING	PROVIDED BUT DISCONTINUED	CPS SERVICES	CURRENTLY RECEIVING	PROVIDED BUT DISCONTINUED	CPS SERVICES
		Treatment Family Home			CPR
		Intensive Targeted Case Management			Day Treatment

FOR DISCHARGE ONLY

DISCHARGE REASON? (CHECK ALL THAT APPLY)

<input type="checkbox"/> Child/Youth Improved	<input type="checkbox"/> Child/Youth's Age
<input type="checkbox"/> Child/Youth's Family discontinued services	<input type="checkbox"/> Child/Youth deceased
<input type="checkbox"/> Child/Youth's Family is moving	<input type="checkbox"/> Other Discharge Reason (Specify: _____)
<input type="checkbox"/> Child/Youth transferred to another service within agency	

PART II: (Please fill out this form as completely and accurately as you can.)

Questions A - G are intended to collect information on the status of the child or youth at the time this form is completed.

A. CASE MANAGER FILLS OUT AND THE INFORMANT IS

Parent/Guardian Relative Other (Relationship to child) _____

B. WHO IS THE CHILD/YOUTH'S LEGAL GUARDIAN? (CHECK ONLY ONE)

<input type="checkbox"/> Both Biological/Adoptive Parents	<input type="checkbox"/> Division of Youth Services (DYS)
<input type="checkbox"/> Mother	<input type="checkbox"/> Division of Family Services (DFS)
<input type="checkbox"/> Father	<input type="checkbox"/> Juvenile Court
<input type="checkbox"/> Grandparent(s)	<input type="checkbox"/> Other (Specify: _____)
<input type="checkbox"/> Other Relative	

C. WITH WHOM IS THE CHILD/YOUTH LIVING? (CHECK ONLY ONE)

<input type="checkbox"/> Living with Biological/Adoptive Parents	<input type="checkbox"/> Psychiatric Inpatient Unit
<input type="checkbox"/> Mother	<input type="checkbox"/> Treatment Family Home - DMH
<input type="checkbox"/> Father	<input type="checkbox"/> Residential Treatment Center
<input type="checkbox"/> Grandparent(s)	<input type="checkbox"/> Juvenile Detention
<input type="checkbox"/> Living with others in private home	<input type="checkbox"/> CSTAR Residential
<input type="checkbox"/> Foster Care	<input type="checkbox"/> Other (Specify: _____)
<input type="checkbox"/> Group Home	

D. WHAT IS THE CHILD/YOUTH'S EDUCATIONAL INVOLVEMENT? (CHECK ALL THAT APPLY)

<input type="checkbox"/> Regular Classroom	<input type="checkbox"/> Alternative
<input type="checkbox"/> Special Education - Regular Classroom	<input type="checkbox"/> Diploma/GED/Adult Basic Education
<input type="checkbox"/> Special Education - Resource Room	<input type="checkbox"/> Home Schooled
<input type="checkbox"/> Special Education - Self-Contained Classroom-Part Day	<input type="checkbox"/> No Education Activity (Specify: _____)
<input type="checkbox"/> Special Education - Self-Contained Classroom-Full Day	<input type="checkbox"/> Other (Specify: _____)
<input type="checkbox"/> Special Education - Home Bound	

E. DOES CHILD/YOUTH RECEIVE ASSISTANCE THROUGH "504"?

YES NO

F. DOES CHILD/YOUTH HAVE AN INDIVIDUAL EDUCATION PLAN (IEP)?

YES NO

G. DOES CHILD/YOUTH GO TO SCHOOL IN HIS/HER LOCAL SCHOOL DISTRICT?

YES NO

Questions H - O are intended to collect information on the status of the child or youth **during the last 6 months or past month if Review for SOC/DFS Level 4.**

H. HAS CHILD/YOUTH RECEIVED OUT OF HOME CARE? (CHECK ALL THAT APPLY)

- No out of home care received
- Psychiatric Hospitalization
If yes, how many times admitted? _____
Total Number of days _____
If SOC/DFS Level 4, Location within the past month:
 City/County In State Out of State
- Substance Abuse Hospitalization/Residential Treatment
If yes, how many times admitted? _____
Total Number of days _____
If SOC/DFS Level 4, Location within the past month:
 City/County In State Out of State
- Juvenile Detention
If yes, how many times admitted? _____
Total Number of days _____
If SOC/DFS Level 4, Location within the past month:
 City/County In State Out of State

- Foster Home - DFS
If yes, how many times admitted? _____
Total Number of days _____
If SOC/DFS Level 4, Location within the past month:
 City/County In State Out of State
- Group Residential Setting
If yes, how many times admitted? _____
Total Number of days _____
If SOC/DFS Level 4, Location within the past month:
 City/County In State Out of State
- Treatment Family Home - DMH
If yes, how many times admitted? _____
Total Number of days _____
If SOC/DFS Level 4, Location within the past month:
 City/County In State Out of State

I. HAS CHILD/YOUTH BEEN INVOLVED WITH AGENCIES OTHER THAN COMPREHENSIVE PSYCHIATRIC SERVICES? (CHECK ALL THAT APPLY)

- No involvement with other agencies
- Social Services - (Division of Youth Services)
- Juvenile/Family Court
- School System
- Social Services - (Division of Family Services)
- Substance Abuse Agency
- MRDD
- Other (Specify: _____)

J. HAS CHILD/YOUTH HAD ACCESS TO ROUTINE HEALTH SERVICES?

	NEED		RECEIVED	
Routine Physical Health	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Dental	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Vision	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Emergency	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO

K. IS SPECIAL LANGUAGE OR COMMUNICATION ASSISTANCE (INTERPRETING IN ANY LANGUAGE OTHER THAN ENGLISH, INCLUDING AMERICAN SIGN LANGUAGE, DOCUMENT TRANSLATION, ETC.) NEEDED?

- American Sign Language YES NO
 - Other Language YES NO
 - Other Communication Assistance YES NO
- If yes, specify _____
If yes, specify _____

L. WAS THE CLIENT ADVISED THAT SPECIAL LANGUAGE OR COMMUNICATION ASSISTANCE (INTERPRETING IN ANY LANGUAGE OTHER THAN ENGLISH, INCLUDING AMERICAN SIGN LANGUAGE, DOCUMENT TRANSLATION, ETC.) WAS AVAILABLE?

- YES NO

M. HAS SPECIAL LANGUAGE OR COMMUNICATION ASSISTANCE (INTERPRETING IN ANY OTHER LANGUAGE OTHER THAN ENGLISH, INCLUDING AMERICAN SIGN LANGUAGE, DOCUMENT TRANSLATION, ETC.) BEEN RECEIVED?

- YES NO

N. HAS CHILD/YOUTH BEEN INVOLVED WITH LAW ENFORCEMENT? (CHECK ALL THAT APPLY)

- No legal involvement
- Child/youth was victim of crime
- Law enforcement contact but no charges filed
- Referral to Juvenile Office
 - Status Offense
 - Delinquent Offense
- Preadjudication action (Check all that apply)
 - Detention
 - Home
 - Certified as an adult
 - Other (Specify: _____)
- Disposition
 - Informal Adjustment, no supervision
 - Informal Adjustment, with supervision
 - Formal Adjustment, Out of home placement by court
 - Formal Adjustment, Commit to DYS
 - Formal Adjustment, Commit to DFS
 - Formal Adjustment, DMH for out of home service
 - Formal Adjustment, In-home services
 - Petition not found true

O. HAS CHILD/YOUTH BEEN SUSPENDED FROM SCHOOL? (CHECK ALL THAT APPLY)

- No suspensions
- In School Suspension Number of Times (1-3, 4-8, 9-more) _____ Total Days Suspended (1-5, 6-10, 10-15, 16-more) _____
- Out of School Suspension Number of Times (1-3, 4-8, 9-more) _____ Total Days Suspended (1-5, 6-10, 10-15, 16-more) _____
- Expelled Number of Times (1-3, 4-8, 9-more) _____

P. IF CHILD/YOUTH IS IN SOC/DFS LEVEL 4, HOW MANY DAYS HAS THE SCHOOL BEEN IN SESSION DURING THE PAST 30 DAYS?

Number of days _____

Q. IF THE CHILD/YOUTH IS IN SOC/DFS LEVEL 4, HOW MANY DAYS HAS THE CHILD ATTENDED SCHOOL WITHIN THE PAST 30 DAYS?

Number of days attended _____