

**Behavioral Health Home Screening Tool**

**Cyber ID #/ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CM Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Screening: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Supervisor Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* If the youth does not have any if the following conditions, please check here

Medical Condition (Check all that Apply):

* Asthma
* Hypertension
* Diabetes Mellitus
* Cystic Fibrosis
* Kidney/Renal Disease
* Obesity (BMI >85th percentile)
* Seizure Disorder
* Eating Disorder
* Cardiac Disorder (requiring the care of a cardiologist at least yearly)
* Hypothyroidism
* Hyperthyroidism
* Polycystic Ovarian Syndrome
* Pre-Diabetes
* Autism with GI Concerns (GERD, constipation, diarrhea, IBS)
* Chronic Migraines
* Substance Use Disorder
* Sickle Cell Disease
* Developmental Disability (with co-occuring medical condition i.e. cerebral palsy, genetic or chromosomal disorders, spina bifida, fetal alcohol syndrome, neurological disorders, metabolic disorders, prematurity related disorders)

Does the youth have NJ Medicaid/ Family Care? (3560 does not qualify)

Y N

Is the youth receiving nursing services through DCP&P (DCP&P custody in an out of home treatment or placement or being monitored by DCP&P Child Health Unit)?

 Y N

Would the youth/family benefit from assistance with managing this chronic health condition?

 Y N

Is the youth/family interested in receiving a Behavioral Health Home assessment?

 Y N

I accept/ decline a Behavioral Health Home Services assessment at this time.

**Youth Signature (age 14 and older) Date**

**Parent/Guardian Signature Date**

**CMO Worker Signature Date**

*Revised 5/10/17*