

**ENCLOSURE B – QUALIFIED INDIVIDUAL ASSESSMENT REPORT**

<b>Youth's* Name:</b>	<b>Preferred Name:</b>
<b>Pronouns:</b>	<b>Date of Birth:</b>
<b>This Child is or may be an Indian Child:</b> Yes                      No	<b>If yes, Child's Tribe(s):</b>
<b>ICWA Status:</b>  <b>Tribal Representative(s) Name:</b>  <b>Phone Number:</b>  <b>Email:</b>	
<b>Primary Language:</b>	<b>Medi-Cal Client ID Number (CIN):</b>
<b>County of Jurisdiction:</b>	<b>CWS/ CMS Client ID Number:</b>
<b>Referral Submitted by (Referring Agency, Worker Name):</b>	<b>Date Referral Received:</b>
<b>Lead Agency:</b> CWS                      Probation  Tribes with a California IVE Agreement  *Dual Status/ CWS/ Tribes and Probation	<b>Caseworker:</b>  <b>Agency:</b>  <b>Contact Phone Number:</b>  <b>Email:</b>
<b>QI Completing QI Assessment Report:</b>	<b>Date QI Assessment Report Completed:</b>
<b>Youth's Current Placement:</b>	

***\*For purposes of this form, the term "youth" is used to refer to children, youth, minors, and nonminor dependents (NMDs).***

**Section A: Summary and Recommendations**

**Provide a brief integrated summary of the data gathered during the assessment (i.e., the rationale that supports the level of care determination). Identify any limitations to conducting the Qualified Individual (QI) Assessment (e.g., youth is absent without authorization, consent not obtained and/or Release of Information not in place, etc.).**  
**Minimum Required Documentation Received with the Referral:    Yes        No**

Most appropriate level of care recommended:

Section B: Information Utilized in Determination

Identify the most recent information available and specify the date(s) for each.

Comprehensive Mental Health Assessment:  
Date(s):  
Mental Health Treatment Plan / Care Plan:  
Date(s):  
Other Assessment records (e.g., Developmental, Educational, Psychiatric / Psychological, Medical):  
Date(s):  
Screening (e.g., Trauma, Substance Use, other):  
Date(s):  
IP-CANS  
Date(s):  
CFT Meeting(s) (attend in-person, by telephone, or by telehealth):  
Date(s):  
Previous 12 months of CFT Action Plan Meeting Notes  
Date(s):  
CFT members interviewed (Professionals and Family Members/ Natural Supports):  
Name: Relationship:  
Name: Relationship:  
Name: Relationship:  
Name: Relationship:  
  
Other Family members / Significant Support (non-CFT) interviewed:  
Name: Relationship:  
Name: Relationship:  
Name: Relationship:  
Name: Relationship:  
  
Youth interviewed  
Date(s):  
Youth has provided their specific treatment, services, and placement preferences.  
Parent or caregiver has provided their specific treatment, services, and placement preferences.  
Tribe/Tribal Representative Consulted:  
Date(s):  
Behavioral Health Provider(s), including Tribal Behavioral Health Provider interviewed:

Name:	Title:
Name:	Title:

Regional Center / Regional Center Provider interviewed:

Name:	Title:
Name:	Title:

Individual Education Plan (IEP) or 504 Plan.  
Other relevant information, not specified in this list:

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Section C: Integrated Practice (IP) Child and Adolescent Needs and Strengths (CANS) Assessment

List the Child’s Needs and Risk Behaviors that require action (ratings of 2 or 3). If there are more than 12 items with ratings of 2 or 3, then describe those items in narrative below.

Use the following categories and action levels:

2 – Action is required to ensure that the identified need is addressed; need is interfering with functioning.

3 – Need is dangerous or disabling; requires immediate and/or intensive action.

*Note: Any information pertaining to substance use cannot be disclosed without proper permissions:*

See [ACL 18-85/MHSUDS IN 18-029](#) regarding sharing CANS information.

IP-CANS Item(s)	2 or 3	IP-CANS Item(s)	2 or 3
1.		7.	
2.		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

Discuss the youth’s strengths identified in the IP-CANS:

## Section D: Goals and Treatment Needs

**Youth-specific short- term mental and behavioral health goals and treatment needs:**

**Youth-specific long-term mental and behavioral health goals and treatment needs:**

**Considerations for any known multi-agency care coordination needs that should be planned for during discharge and aftercare planning, upon the youth's transition to a family-based setting, if applicable:**

### Section E: Identified or Potential Caregiver for Permanency Planning



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**Discuss key strengths of any identified or potential caregiver (e.g., reference the IP-CANS) that would assist in meeting the youth’s needs.**

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**Provide any additional behavioral health considerations for the youth in identifying any potential caregiver to support permanency (e.g., interpersonal relationship, communication skills, social skills, etc.).**

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Identify interventions (e.g., mental health, education, community supports, strength building activities, therapeutic interventions that utilize self-expression, etc.) currently in place, interventions currently in place with recommended modifications, interventions recommended and not currently in place, and any service-related referrals recommended to be put in place to address the youth's specific short-term and long-term mental and behavioral health goals and treatment needs.

**Identify specific interventions for the child/youth/NMD:**

<b>Intervention</b>	<b>Current Service, Referral, or Recommendation</b>	<b>Briefly State Rationale</b>
Therapeutic Behavioral Services (TBS)	Current Current with Recommended Modification Recommended, not currently in place Referral Not Applicable	
Intensive Home-Based Services (IHBS)*	Current Current with Recommended Modification Recommended, not currently in place Referral Not Applicable	
Intensive Care Coordination (ICC)	Current Current with Recommended Modification Recommended, not currently in place Referral Not Applicable	
Therapeutic Foster Care (TFC)*	Current Current with Recommended Modification Recommended, not currently in place Referral Not Applicable	
Individual Therapy	Current Current with Recommended Modification Recommended, not currently in place Referral Not Applicable	
Family Therapy	Current Current with Recommended Modification Recommended, not currently in place Referral Not Applicable	

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<b>Intervention</b>	<b>Current Service, Referral, or Recommendation</b>	<b>Briefly State Rationale</b>
Group Therapy	Current Current with Recommended Modification Recommended, not currently in place Referral Not Applicable	
Wraparound Program*	Current Current with Recommended Modification Recommended, not currently in place Referral Not Applicable	
Substance Use Disorder (SUD) Treatment Services	Current Current with Recommended Modification Recommended, not currently in place Referral Not Applicable	
Medication Support Services	Current Current with Recommended Modification Recommended, not currently in place Referral Not Applicable	
Enhanced Care Management (ECM)	Current Current with Recommended Modification Recommended, not currently in place Referral Not Applicable	
Speech and Language Services	Current Referral Not Applicable	
Occupational Therapy	Current Referral Not Applicable	
Physical Therapy	Current Referral Not Applicable	

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<b>Other Supports and Services</b>	<b>Current Service or Referral Recommended</b>	<b>Briefly State Rationale</b>
Applied Behavioral Analysis (ABA)	Current Recommended, not currently in place Referral Not Applicable	
Special Education- Individual Education Plan (IEP)/ 504 Accommodation Plan	Current Referral Not Applicable	
Educationally Related Mental Health Services (ERMH)	Current Current with Recommended Modification Recommended, not currently in place Referral Not Applicable	
Intensive Services Foster Care (ISFC)*	Current Current with Recommended Modification Recommended, not currently in place Referral Not Applicable	
<b>QI Suggestions for CFT Direct Activities</b>	<b>Current Service or Referral Recommended</b>	<b>Briefly State Rationale</b>
School and Community Based Activities (Strength building activities)	Current Current with Recommended Modification Recommended, not currently in place Referral Not Applicable	
Regular Educational Support Services	Current Referral Not Applicable	
Family Finding and Engagement	Current Current with Recommended Modification Recommended, not currently in place Referral Not Applicable	
Other (specify)		
Other (specify)		
Other (specify)		

\* Service availability may be restricted to family-based setting.

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**Discuss how the interventions and treatment should be conducted in a manner consistent with the prevailing social and cultural conditions and way of life of the youth's community or child's tribe, in the case of an Indian child.**

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**For an Indian child, document the steps taken by the QI to consult with the Indian child's Tribe, and the mental and behavioral health interventions and treatment that the program will implement to improve the functioning and well-being. Also document how the interventions and treatment will be conducted in a manner consistent with the prevailing social and cultural conditions and way of life of the Indian child's Tribe.**

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**Section G: Can the assessed needs of the youth be met in a family-based setting or, in the case of an Indian child, a placement that conforms with the Indian child welfare act, including tribally approved home?**

**Yes (if yes, skip to Section IX)**

**No (if no, provide information below)**

**Discuss the barriers and the reasons why the needs of the youth cannot be met by family members, in a tribally approved home in the case of an Indian child, or in another family-based setting. A shortage or lack of foster family or tribally approved homes shall not be an acceptable reason for determining that the needs of the youth cannot be met in a foster family home.**



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### **Section H: Recommendations: Alternative Settings**

**(Complete Section VIII only if family-based setting is not recommended)**

**If the youth's needs cannot be met with family members, in another family-based setting, or tribally approved home, select the setting, as specified in the Social Security Act (42 U.S.C. 675(k)(2)), that would provide the most effective and appropriate level of intervention for the youth in the least restrictive environment, consistent with the short- and long-term goals for the youth as specified in the permanency plan.**

Short-Term Residential Therapeutic Program (STRTP)

Community Treatment Facility (CTF)

A setting specializing in providing prenatal, postpartum, or parenting supports for youth.

In the case of a youth who has attained 18 years of age, a supervised setting in which the child is living independently (e.g., Transitional Housing Program for Non-Minor Dependents, Supervised Independent Living Program).

A setting providing high-quality residential care and supportive services to children and youth who have been found to be, or are at risk of becoming, sex trafficking victims.

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**Discuss why the above selected setting is the most appropriate level of care in the least restrictive environment. Discuss any enhancements or specialized programming that would aid the youth in meeting their treatment needs (e.g., STRTP, STRTP of one, STRTP with specialized program such as substance use, sexual offender, criminogenic needs, etc.).**

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**Section I: Child and Family Team Placement Recommendation**

List the recommended placement of the Child and Family Team (CFT). If applicable, discuss why the QI level of care recommendation is different than the placement preferences of the CFT and the Tribe, in the case of an Indian child.

Licensed Mental Health Professional (LMHP)/Licensed Practitioner of the Healing Arts (LPHA) Printed Name:

LMHP/LPHA Signature:	Date:
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