# MCBH MyAvatar: **2.0 CalAIM Assessment**

| Assessment type | Date of assessment | PATID |
|---|---|---|
| ◯ Initial ◯ Update | | |
| | | Completed by |
| | | |
| | | Clinical Staff Approving Assessment |
| | | |

| Presenting Problem |
|---|
| Presenting Problem(s): Mental Health and Substance Use: |

**Why are you seeking services? Tell me what you have been experiencing and for how long. How do these symptoms/experiences affect your life?**

**Additional testing/screening results (i.e. psychology testing, Beck Inventory, CBCL, etc.**

**Identified Impairment(s)**

- ☐ **Family relationships**
- ☐ **Interpersonal relationships**
- ☐ **Employment**
- ☐ **Educational/academic performance**
- ☐ **Self-care/activities of daily living**
- ☐ **Food/shelter security**
- ☐ **Physical health**
- ☐ **Substance use/abuse**

**Additional impairment information**

## History and Co-occurring Conditions

### History of previous mental health condition and services

**Are there other mental health conditions you have experienced in the past? Have you received treatment to address them? What type of treatment, for how long, and was it helpful?**

☐ **Member does not have a history of mental health conditions and/or did not share this information at the time of the assessment.**

### History of previous substance use condition and services

**Are there other substance use challenges you have experienced in the past? Have you received treatment to address them? What type of treatment, for how long, and was it helpful?**

☐ **Member does not have a history of substance use and/or did not share this information at the time of the assessment.**

## Description of current and previous physical health conditions

**How would you describe your current physical health? Are there any medical condition(s) you have struggled with in the past? Have you received treatment for any of these? Do you have any disturbances in sleep or appetite or allergies? Anything else you would like to share?**

☐ **Member does not have a history of physical health conditions and/or did not share this information at the time of the assessment.**

**Member has a primary care provider**

○ **Yes** ○ **No**

**Name of the primary care provider**

Date of last visit

## Trauma

☐ **Member does not have a history of trauma and/or did not share this information at the time of assessment.**

## Trauma Exposure

**Have you ever experienced a traumatic event, in which you feared for your safety or the safety of a loved one? Examples of trauma include physical abuse, sexual abuse, emotional abuse, neglect, partner violence, immigration trauma, etc.?**

## Trauma Exposure:

☐ Attachment Trauma ☐ Homelessness ☐ Partner Violence

☐ Bullying ☐ Justice Involvement ☐ Physical Abuse

- [ ] Child Welfare System
- [ ] Combat/Military
- [ ] Community Violence
- [ ] Death of a Loved One
- [ ] Emotional Abuse
- [ ] Geographic Relocation
- [ ] Medical
- [ ] Natural Disaster
- [ ] Neglect
- [ ] Non-violent Crime
- [ ] Orientation/Sexuality
- [ ] Parental Separation
- [ ] Pregnancy/Infant Loss
- [ ] Race/Ethnicity/Culture
- [ ] Sexual Abuse
- [ ] Trafficking
- [ ] Violent Crime

## Trauma Response/Symptoms

**As a result of the trauma you experienced, did you or do you continue to experience any of the following responses?**

### Intrusive Memories

- [ ] Recurring distressing memories of the event
- [ ] Flashbacks (reliving of the event)
- [ ] Disturbing dreams or nightmares

### Negative Changes in Thoughts or Mood

- [ ] Negative thoughts about oneself, other people, or the world
- [ ] Memory problems
- [ ] Feeling emotionally "numb"

### Avoidance

- [ ] Avoiding talking or thinking about anything that triggers memories of the event
- [ ] Avoiding talking about the event
- [ ] Fear of leaving their home
- [ ] Isolating from family and others

### Changes in Physical or Emotional Reactions

- [ ] Becoming startled or frightened easily
- [ ] Self-destructive behavior
- [ ] Irritability or angry outbursts
- [ ] Always on the lookout for danger

## Additional Trauma Information

**Is there anything else you would like to add related to your trauma exposure and response?**

## Psychosocial Information

### Family Information

**Can you tell me about your living situation? What was it like growing up with your family? What challenges or significant events did you experience in relation to your family unit?**

**Family member(s) or caregiver(s) with a mental health condition**

- ◯ Yes
- ◯ No
- ◯ Uncertain

**Family member(s) or caregiver(s) with a substance use condition**

- ◯ Yes
- ◯ No
- ◯ Uncertain

## Social and Life Circumstances

**Who can you count on for social support? How do you spend your free time? Do you experience any challenges with activities of daily living?**

## Cultural Considerations

**What are your preferred pronouns? How do you identify in terms of your gender and sexual orientation? Can you tell me about your cultural and/or religious/spiritual practices? Does this impact you in any way?**

## Other Relevant Information

**Have you been arrested or on probation/parole or had any other legal involvement? Tell me about your educational experiences. What about your employment background? Are you receiving any financial support such as SSI/disability benefits?**

## Risk/Safety and Protective Factors

### Risk Factors

**Have you experienced any of the following risk factors in the last 30 days? Have you had any thoughts about killing yourself? What about thoughts of seriously harming or killing other people? Are you able to get your basic needs met such as food, shelter, and clothing?**

- ☐ Aggressive behavior towards others
- ☐ Agitation or severe anxiety
- ☐ Alcohol or substance use
- ☐ Chronic physical pain/acute medical issues
- ☐ Command hallucinations to hurt self/others
- ☐ Family history of suicide
- ☐ Highly impulsive behaviors
- ☐ Hopelessness
- ☐ Major depressive episode
- ☐ Method for suicide available (gun/pills)
- ☐ Mixed affective episode
- ☐ Perceived burden on family or others
- ☐ Recent ER visit for MH or SUD (within the last year)
- ☐ Recent loss(es)
- ☐ Refuses or unable to agree to safety plan
- ☐ Sexual abuse
- ☐ Significant negative financial issues
- ☐ Significant negative legal issues
- ☐ Significant negative relationships
- ☐ Suicidal/homicidal ideation

### Additional Risk Factor Information

**Have you experienced any other risk factors? What about in the last year?**

## Protective Factors

**Do any of the following protective factors apply to you?**

- [ ] Identifies reason for living
- [ ] Responsibility to family or others (i.e. pets)
- [ ] Supportive social network/family
- [ ] Engaged in work or school
- [ ] Belief that suicide is normal
- [ ] Fear of death or dying because of pain/suffering
- [ ] Access to care and basic needs
- [ ] Medication adherence
- [ ] Engaged in treatment
- [ ] Strong coping skills
- [ ] Willing to ask for help or engaging in safety planning
- [ ] Connection to religion/spirituality

## Additional protective factor information and member identified strengths

**Are there any other protective factors you would like to add? What are your strengths? What are some good things that your loved ones and friends see in you?**

## Safety planning information

**In case of emergencies, who can you reach out to for support? What else can you do to keep yourself safe?**

## Clinical Summary, Diagnostic Impression, and Recommendation

### Current Mental Status

☐ **Unable to complete**

| Reason |
| --- |
| |

### Appearance

☐ Appropriate ☐ Neat ☐ Bizarre

☐ Disheveled ☐ Odiferous

### Speech

☐ Normal ☐ Pressured ☐ Mute ☐ Loud

☐ Minimal responses ☐ Soft ☐ Stuttered ☐ Hyperverbal

### Thought Process

☐ Logical ☐ Tangential

☐ Circumstantial ☐ Concrete

☐ Thought Blocking

### Thought Content

☐ Appropriate ☐ Bizarre Ideation

☐ Paranoid Delusions ☐ Somatic Delusions

☐ Grandiose Delusions ☐ Persecutory Delusions

### Judgment

☐ Fair ☐ Impaired

☐ Poor ☐ Limited

☐ Good

### Mood

☐ Appropriate ☐ Depressed ☐ Irritable

☐ Angry ☐ Euphoric ☐ Sad

☐ Anxious ☐ Fearful ☐ Silly

**Affect**

- [ ] Congruent
- [ ] Appropriate
- [ ] Labile
- [ ] Flat
- [ ] Blunted
- [ ] Expansive
- [ ] Inappropriate
- [ ] Constricted

**Insight**

- [ ] Fair
- [ ] Impaired
- [ ] Poor
- [ ] Limited
- [ ] Good

**Recent memory**

- [ ] Intact
- [ ] Poor Recent
- [ ] Poor Remote
- [ ] Poor Immediate
- [ ] Amnesia

**Orientation**

- [ ] Time
- [ ] Poor Recent
- [ ] Person
- [ ] Poor Immediate

## Additional MSE information

## Clinical Summary and Diagnostic Impression

**Member has a mental health condition:**

Yes No Uncertain

**Completed Diagnosis:**

Yes No

**Member has a substance use condition:**

Yes No Uncertain

**Based on this assessment, the member meets medical necessity for Specialty Mental Health Services.**

## Level of Care and Recommendations

**Specialty Mental Health Services**

- Mental Health Services
- Medication Support Services
- Case Management
- Day Treatment Intensive
- Day Rehabilitation
- Adult Residential
- Crisis Residential
- Intensive Care Coordination (0–21 y/o only)
- Intensive Home-Based Services (0–21 y/o only)
- Therapeutic Foster Care (0–21 y/o only)
- Therapeutic Behavioral Services (0–21 y/o only)
- Crisis Intervention
- Crisis Stabilization
- Psychiatric Health Facility Services
- Psychiatric Inpatient Hospital Services

**Substance Use Services**

- Substance Use Referral

**Non-Specialty Mental Health Services**

- Referral to Primary Care
- Referral to Managed Care Plan

**Other**

- Services Not Recommended
- Member Declined
- Unable to Complete Assessment

**Additional Recommendation Details (must include purpose, frequency and intensity for Case Management ONLY)**