SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

SAN MATEO COUNTY
ASSESSMENT TOOL- YOUTH (Paper Version)

Based on the ASAM Criteria [3rd Edition] Multidimensional Assessment

Demographic information

Name:	Date:	Phone Number: ☐ Mobile Okay to leave text or voicemail? ☐ Yes ☐ No
Address:		
Date of Birth:	Age:	Gender:
Race/Ethnicity:	Preferred Language:	Medi-Cal #: Other ID# (Plan):
Insurance Type: ☐ None	☐ Medicare (Plan):	☐ Medi-Cal (Plan): ☐ Private (Plan): ☐ Other (Plan):
Parent/Legal Guardian:		Relationship:
Living Arrangement: ☐ Parent/Legal Guardian	☐ Independent Living	☐ Homeless ☐ Agency/Other (specify):
Referred by: ☐ Probation	☐ Family ☐ Self	☐ Other (specify):

Please list all current health providers (physicians, clinicians, therapists, or counselors):

Name	Type of Provider	Contact Information

Please list all current medication(s) and/or herbal supplements:

Medication	Dose/Frequency	Duration	Reason

Explanation of why client is currently seeking treatment - Current symptoms, functional impairment, severity, duration of symptoms, other issues (e.g., unable to work/go to school, relationship issues, housing problems):

_____

_____

_____

_____

Client Name: _____

Medi-Cal ID: _____

Treatment Provider: _____

Dimension 1: Substance Use, Acute Intoxication, Withdrawal Potential

1. Substance Use History:

DSM-5 Substance-Related Disorders	Lifetime Use	Age First Use	Past Year Use	Past Year Duration	Amount of Current Use	Frequency	Route of Use	Date of Last Use
			Use in past year (If none, proceed to next illicit drug. No need to complete remaining items in row)	# months past year	Use in last month	Daily, weekly, monthly, Etc.)		
Alcohol	□ Yes □ No		□ Yes □ No					
Cannabis (Marijuana)	□ Yes □ No		□ Yes □ No					
Hallucinogens	□ Yes □ No		□ Yes □ No					
Inhalants	□ Yes □ No		□ Yes □ No					
Opioid: Heroin	□ Yes □ No		□ Yes □ No					
Opioid: Pain Medications	□ Yes □ No		□ Yes □ No					
Sedatives, Hypnotics, or Anxiolytics (benzodiazepines, sleeping pills)	□ Yes □ No		□ Yes □ No					
Stimulant: Cocaine	□ Yes □ No		□ Yes □ No					
Stimulant: Methamphetamine, other Amphetamines	□ Yes □ No		□ Yes □ No					
Tobacco (nicotine products)	□ Yes □ No		□ Yes □ No					
Over-the-Counter Medications (Cough Syrup, Diet Aids)	□ Yes □ No		□ Yes □ No					
Other:	□ Yes □ No		□ Yes □ No					

Client Name: _____

Medi-Cal: _____

Treatment Provider: _____

Additional Information: _____

_____

2. Have you ever experienced an overdose? ☐ Yes ☐ No

Please describe: _____

_____

3. In the past year, have you found yourself using substances for a longer period of time than you intended? ☐ Yes ☐ No

Please describe: _____

_____

4. Have you ever experienced being physically ill from withdrawal symptoms when you stop using substances? ☐ Yes ☐ No

** Withdrawal signs & symptoms: e.g. nausea & vomiting; excessive sweating; fever, tremors; seizures; rapid heart rate; blackouts; hallucinations; "DTs" (aka: delirium tremens); anxiety; agitation; depression*

Please describe: _____

_____

5. Are you currently experiencing any withdrawal symptoms as a result of your substance use? ☐ Yes ☐ No

Please describe specific symptoms (consider immediate referral for medical evaluation): _____

_____

6. Do you have a history of serious seizures or life-threatening symptoms during withdrawal from your substance use?

☐ Yes ☐ No

Please describe and specify withdrawal substance(s): _____

_____

7. In the past year, have you found yourself needing to use more substances to get the same high? ☐ Yes ☐ No

Please describe: _____

_____

8. Has your substance use recently changed (increased/decreased/changed route of use)? ☐ Yes ☐ No

Please describe: _____

_____

9. Have you ever received treatment for your substance use? ☐ Yes ☐ No

Substance	When	Where	Level of Care	Length of Treatment

Please describe your treatment experience(s) and outcome(s):

_____

_____

Client Name: _____

Medi-Cal: _____

Treatment Provider: _____

Please rate the client's severity for this dimension by circling one of the following levels of severity:

Dimension 1 (Substance Use, Acute Intoxication, Withdrawal Potential) Severity Rating				
0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
No signs of withdrawal/intoxication present	Mild/moderate intoxication, interferers with daily functioning. Minimal risk of severe withdrawal. No danger to self/others.	May have severe intoxication but responds to support. Moderate risk of severe withdrawal. No danger to self/others.	Severe intoxication with imminent risk of danger to self/others. Risk of severe manageable withdrawal.	Incapacitated. Severe signs and symptoms. Presents danger, i.e. seizures. Continued substance use poses an imminent threat to life.

Additional Comments:_____

_____

Dimension 2: Biomedical Conditions and Complications

10. Do you have any of the following physical health conditions or disabilities?

☐ Asthma/Respiratory	☐ Heart Problems	☐ Thyroid Problems	☐ Muscle/Joint Problems
☐ Seizure/Epilepsy/ Neurological	☐ High Blood Pressure	☐ Kidney Problems	☐ Vision Problems
☐ Sleep Problems	☐ High Cholesterol	☐ Liver Problems	☐ Hearing Problems
☐ Diabetes	☐ Blood Disorder	☐ Chronic Pain	☐ Dental Problems
☐ Pregnant	☐ Stomach/Intestinal Problems	☐ Cancer (specify): _____	
☐ Sexually Transmitted Infection(s):		☐ Other Infectious Conditions (Hepatitis, HIV, TB, etc.):	
☐ Allergies: _____		☐ Other: (i.e., involved in accident recently, etc.) _____	

11. Are any of the physical health conditions or disabilities above related to your substance use or current medical health condition(s)? ☐ Yes ☐ No

Please describe: _____

_____

12. In the past year, have you continued using substances despite it contributing to health issues? ☐ Yes ☐ No

Please describe: _____

_____

13. Do any of these health conditions have an impact on your daily life or functioning? ☐ Yes ☐ No

Please describe: _____

_____

14. Have you ever been hospitalized or been evaluated in an emergency room for any physical health problems?

☐ Yes ☐ No

Client Name: _____

Medi-Cal: _____

Treatment Provider: _____

Please describe: _____

_____

15. For assessor to answer: Does the youth client report medical symptoms that would be considered life-threatening or require immediate medical attention? ☐ Yes ☐ No

** If yes, consider immediate referral to emergency room or call 911*

Please describe: _____

_____

Please rate the client's severity for this dimension by circling one of the following levels of severity:

Dimension 2 (Biomedical Conditions and Complications) Severity Rating				
0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
Fully functional/ able to cope with discomfort or pain.	Mild to moderate symptoms interfering with daily functioning. Adequate ability to cope with physical discomfort.	Some difficulty tolerating physical problems. Acute, nonlife threatening problems present, or serious biomedical problems are neglected.	Serious medical problems neglected during outpatient or intensive outpatient treatment. Severe medical problems present but stable. Poor ability to cope with physical problems.	Incapacitated with severe medical problems.

Additional Comments: _____

_____

Dimension 3: Emotional, Behavioral, or Cognitive Conditions or Complications

16. Have you ever seen or talked to a counselor or therapist for emotional or behavioral issues? ☐ Yes ☐ No

Please describe: _____

_____

When	Where	Treatment Setting	Diagnosis	Length of Treatment

17. Do you consider any of the following behaviors or symptoms to be problematic for you (e.g., use of substances to cope with emotional, behavioral, or mental health issues as checked below)?

Mood			
☐ Feeling sad or depressed	☐ Loss of pleasure or interest in things	☐ Feelings of hopelessness or inferiority *(e.g., lower than others)*	☐ Significant changes in appetite or sleep
☐ Racing thoughts *(e.g., fast, repetitive thought patterns about a particular topic)*	☐ Rapid or pressured speech *(e.g., fast and virtually nonstop talking that is usually cluttered and hard to interrupt)*	☐ Feeling overly ambitious, grandiose, or narcissistic *(e.g., self-absorbed)*	

Client Name: _____

Medi-Cal: _____

Treatment Provider: _____

Additional Comments:

Stress & Anxiety		
☐ Feeling anxious/nervous	☐ Restlessness *(e.g., persistent feeling of being unable to sit still or relax)*	☐ Having bad dreams/nightmares
☐ Compulsive behaviors *(e.g., trapped in a pattern of repetitive behaviors that are difficult to overcome)*	☐ Obsessive thoughts *(e.g., excessive worry that is difficult to control)*	☐ Experiencing flashbacks (*e.g., a sudden and disturbing vivid memory of a traumatic event in the past)*

Additional Comments:

Psychosis		
☐ Paranoia *(e.g., fearful feelings and thoughts related to threat, persecution, or conspiracy from others)*	☐ Hallucinations (*e.g., having perceptions of something not present. Could include audio, visual, smell)*	☐ Delusions (*e.g. a false belief that is maintained despite contrary evidence*)

Additional Comments:

Attention/Learning		
☐ Becoming easily distracted	☐ Impulsive *(e.g., doing things suddenly and without thinking)*	☐ Difficulty with paying attention
☐ Hyperactivity *(e.g., being overactive and having problems with sitting still)*	☐ Frequently interrupting others	☐ Problems with reading/writing/math

Additional Comments:

Client Name: _____

Medi-Cal: _____

Treatment Provider: _____

Behavioral			
☐ Hostile or violent acts *(e.g., physical fights, forcing sexual activity)*	☐ Uncontrollable anger issues/ outbursts	☐ Bullying or threatening others	☐ Destroying property
☐ Manipulative or deceitful *(e.g., excessive lying)*	☐ Breaking rules/laws often *(e.g., carrying/using dangerous weapons, not going to school/truancy)*	☐ Stealing/theft	☐ Self-harm (e.g., *cutting, picking, burning, etc.*)

Additional Comments:

_____

_____

Other			
☐ Engaging in risky sexual activity *(e.g., unprotected intercourse, sexual victimization, sex in exchange for alcohol/drugs, pornography)*	☐ Severe food restrictions / anorexia	☐ Binging or purging	☐ Preoccupation with gambling

Additional Comments:

_____

_____

18. In the past year, do you continue using substances despite it negatively impacting your emotional, behavioral, and/or mental health? ☐ Yes ☐ No

Please describe: _____

_____

19. Have you ever experienced any kind abuse (physical, emotional, sexual)? ☐ Yes ☐ No

Please describe: _____

_____

20. Have you experienced or witnessed any traumatic or scary event(s) that has stuck with you? ☐ Yes ☐ No

Please describe: _____

_____

21. In the past year, have you felt like hurting or killing yourself? ☐ Yes ☐ No

Please describe: _____

_____

Client Name: _____

Medi-Cal: _____

Treatment Provider: _____

22. In the past year, have you felt like hurting or killing someone else? ☐ Yes ☐ No

Please describe: _____

_____

** If YES to Q#21 or #22, further assess for current suicide/homicide ideation, intent, plan, target(s), access to lethal means and provide appropriate interventions. Consider Duty to Protect (Tarasoff Law).*

Please rate the client's severity for this dimension by circling one of the following levels of severity:

Dimension 3 (Emotional, Behavioral, or Cognitive Conditions and Complications) Severity Rating				
0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
Good impulse control and coping skills. No dangerousness, good social functioning and self-care, no interference with recovery.	Suspect diagnosis of EBC, requires intervention, but does not interfere with recovery. Some relationship impairment.	Persistent EBC. Symptoms distract from recovery, but no immediate threat to self/others. Does not prevent independent functioning.	Severe EBC, but does not require acute level of care. Impulse to harm self or others, but not dangerous in a 24-hr setting.	Severe EBC. Requires acute level of care. Exhibits severe and acute life-threatening symptoms (posing imminent danger to self/others).

Additional Comments: _____

_____

Dimension 4: Readiness to Change

23. What do you enjoy about your substance use?

Please describe: _____

_____

24. What do you NOT enjoy about your substance use?

Please describe: _____

_____

25. In the past year, has your substance use resulted in you failing to complete tasks/activities in important areas of your life? ☐ Yes ☐ No

- ☐ Family relations
- ☐ School status
- ☐ Friendships
- ☐ Legal status
- ☐ Work status
- ☐ Mental Health status
- ☐ Money
- ☐ Hygiene
- ☐ Physical Health status
- ☐ Relationships with others
- ☐ Extracurricular Activities
- ☐ Other: _____
- ☐ Self-esteem
- ☐ Sexual Behavior
- ☐ Social Life

Please describe: _____

_____

26. In the past year, did you continue to use substances despite it affecting the areas listed above? ☐ Yes ☐ No

Please describe: _____

_____

27. In the past year, have you used substances in physically hazardous situations (e.g., under the influence while driving a car, unprotected sexual activity, etc.)? ☐ Yes ☐ No

Please describe: _____

_____

Client Name: _____

Medi-Cal: _____

Treatment Provider: _____

28. Using a scale from 0-10 (with 0 meaning "not at all ready" and 10 "very ready"), how ready are you to stop or cut back your use of: (☐ Not applicable)

Alcohol	Not at all ready	0	1	2	3	4	5	6	7	8	9	10	Very Ready
Marijuana	Not at all ready	0	1	2	3	4	5	6	7	8	9	10	Very Ready
Other drugs	Not at all ready	0	1	2	3	4	5	6	7	8	9	10	Very Ready

Please rate the client's severity for this dimension by circling one of the following levels of severity:

Dimension 4 (Readiness to Change) Severity Rating				
0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
Willing to engage in treatment.	Willing to enter treatment, but ambivalent to the need to change.	Reluctant to agree to treatment. Low commitment to change substance use. Passive engagement in treatment.	Unaware of need to change. Unwilling or partially able to follow through with recommendations for treatment.	Not willing to change. Unwilling/unable to follow through with treatment recommendations.

Additional Comments:

_____

_____

Dimension 5: Relapse, Continued Use, or Continued Problem Potential

29. How would you describe your desire/urge to use substances on a scale from 0 to 10 (with 0 being none and 10 being high)?

None	0	1	2	3	4	5	6	7	8	9	10	High

Please describe: _____

_____

30. In the past year, have you found yourself spending a lot of time getting, using, or recovering from the effects of your substance use? ☐ Yes ☐ No

Please describe: _____

_____

31. In the past year, have you found it hard to cut down or stop your substance use, despite wanting to do so? ☐ Yes ☐ No

Please describe: _____

_____

32. Do you feel that you will continue to use substances without help or additional support? ☐ Yes ☐ No

Please describe: _____

_____

Client Name: _____

Medi-Cal: _____

Treatment Provider: _____

33. Are there important stressors or triggers in your life that contribute to your substance use? ☐ Yes ☐ No

☐ Academic / School Issues	☐ Peer Pressure	☐ Work Pressures
☐ Family Issues	☐ Relationship Problems	☐ Unemployment
☐ Strong Cravings	☐ Sexual victimization	☐ Living Environment
☐ Physical Health Issues	☐ Bullying	☐ Financial Stressors
☐ Chronic Pain	☐ Mental Health Issues	☐ Gang involvement
☐ Weight Issues	☐ Sexual Orientation	☐ Immigration Issues
☐ Legal issues (DCFS, probation, court mandate, etc.)	☐ Gender Identity	☐ Other _____

34. Have you ever attempted to either stop or cut down your substance use? ☐ Yes ☐ No

Please describe: _____

_____

35. What is the longest period of time that you have gone without using substances?

Please describe: _____

_____

36. What do you typically do to deal with your stressors or triggers?

Please describe: _____

_____

37. What would help support you change or stop your substance use?

Please describe: _____

_____

Please rate the client's severity for this dimension by circling one of the following levels of severity:

Dimension 5 (Relapse, Continued Use, or Continued Problem Potential) Severity Rating				
0 *None*	1 *Mild*	2 *Moderate*	3 *Severe*	4 *Very Severe*
Low/no potential for relapse. Good ability to cope.	Minimal relapse potential. Some risk, but fair coping and relapse prevention skills.	Impaired recognition of risk for relapse. Able to self-manage with prompting.	Little recognition of risk for relapse, poor skills to cope with relapse.	No coping skills for relapse/ addiction problems. Substance use/behavior, places self/other in imminent danger.

Additional Comments: _____

_____

Dimension 6: Recovery/Living Environment

38. What is your current living situation (e.g. homeless, living with family/friends/alone)?

Please describe: _____

_____

_____

Client Name: _____

Medi-Cal: _____

Treatment Provider: _____

39. Are you currently in an environment where others (e.g., family, friends, peers, significant others, roommates, neighborhood, school) use substances? ☐ Yes ☐ No

Please describe: _____

_____

Support/Safety

40. Do you have reliable transportation? ☐ Yes ☐ No

Please describe: _____

_____

41. Do you have relationships (e.g., family, peers/friends, mentor, coach, teacher, etc.) that are supportive of you stopping or reducing your substance use? ☐ Yes ☐ No

Please describe: _____

_____

42. Are you currently involved in any relationships or situations (e.g., being bullied, violence in your home and/or neighborhood, abuse (physical, mental, emotional) that pose a threat to your safety and could impact you stopping or reducing your substance use? ☐ Yes ☐ No

Please describe: _____

_____

Education / Employment

43. Are you currently enrolled in school? ☐ Yes ☐ No

Please describe: _____

_____

44. Are you currently employed? ☐ Yes ☐ No

Please describe: _____

_____

45. In the past year, have you experienced any significant problems at home, school or work? ☐ Yes ☐ No

Please describe:

☐ Home _____

☐ School _____

☐ Work _____

Social/Recreational

46. What type of social/recreational activities do you like to do?

Please describe: _____

_____

Client Name: _____

Medi-Cal: _____

Treatment Provider: _____

Please rate the client's severity for this dimension by circling one of the following levels of severity:

Dimension 6 Recovery/Living Environment Severity Rating				
0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
Able to cope in environment/ supportive.	Passive/disinterested social support, but still able to cope.	Unsupportive environment, but able to cope with clinical structure most of the time.	Unsupportive environment, difficulty coping even with clinical structure.	Environment toxic/hostile to recovery. Unable to cope and the environment may pose a threat to safety.

Additional Comments:

_____

_____

Client Name: _____

Medi-Cal: _____

Treatment Provider: _____

Summary of Multi-Dimensional Assessment

Dimension	Severity Rating (based on ratings above)				Rationale for Severity Rating
Dimension 1 Substance Use, Acute Intoxication, Withdrawal Potential	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe	
Dimension 2 Biomedical Condition and Complications	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe	
Dimension 3 Emotional, Behavioral, or Cognitive Condition and Complications	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe	
Dimension 4 Readiness to Change	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe	
Dimension 5 Relapse, Continued Use, or Continued Problem Potential	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe	
Dimension 6 Recovery/Living Environment	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe	

Determining Youth Medical Necessity

In order to deliver specialty substance use disorder (SUD) services to Youth (Age 12-17) and Young Adults (age 18-20), a provider must determine if the youth meets medical necessity. To meet medical necessity, at least one of the two medical necessity criteria outlined below must be met:

1. Have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) 5 for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance- Related Disorders, **and meet the ASAM Criteria for necessary services**

   OR

2. Be assessed to be at-risk for developing a substance use disorder (SUD)

Client Name: _____

Medi-Cal: _____

Treatment Provider: _____

DSM-5 SUD Diagnostic Criteria

Determining if youth meet SUD diagnostic criteria using the DSM-5:

The table below includes the DSM-5 criteria for Substance-Related and Addictive Disorders. These areas are covered in the ASAM assessment questions that are highlighted in grey (throughout the sections above).

- **For each substance, check off any criteria that have been apparent in the <u>past 12 months</u>.**
- **After the completion of the table, put the total number of checked boxes ("yes" responses) in the Criteria Met section.**

	Substance Use Disorder Criteria (DSM-5)	**Name of Substance(s)**		
		#1: _____	**#2:** _____	**#3:** _____
1	Substance often taken in larger amounts or over a longer period than was intended.	☐	☐	☐
2	There is a persistent desire or unsuccessful efforts to cut down or control substance use.	☐	☐	☐
3	A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.	☐	☐	☐
4	Craving, or a strong desire or urge to use the substance.	☐	☐	☐
5	Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.	☐	☐	☐
6	Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.	☐	☐	☐
7	Important social, occupational, or recreational activities are given up or reduced because of substance use.	☐	☐	☐
8	Recurrent substance use in situations in which it is physically hazardous.	☐	☐	☐
9	Continued substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.	☐	☐	☐
10	Tolerance, as defined by either of the following: - A need for markedly increased amounts of the substance to achieve intoxication or desired effect. - A markedly diminished effect with continued use of the same amount of the substance.	☐	☐	☐
11	Withdrawal, as manifested by either of the following: - The characteristic withdrawal syndrome for the substance. - Substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.	☐	☐	☐
	Total Number of Criteria Met	0	0	0

List of Substance Use Disorder(s) and Severity Level that Meet DSM-5 Criteria:

_____ ☐ Mild (2-3) ☐ Moderate (4-5) ☐ Severe (6+)

_____ ☐ Mild (2-3) ☐ Moderate (4-5) ☐ Severe (6+)

_____ ☐ Mild (2-3) ☐ Moderate (4-5) ☐ Severe (6+)

Client Name: _____

Medi-Cal: _____

Treatment Provider: _____

"At-Risk": If clients do not meet the DSM-5 criteria for a substance use disorder, they can also meet medical necessity by meeting the "at-risk" criteria for *Youth (age 12-17) and Young Adults (age18-20), as specified in the "**At-Risk Determination Tool**" below.*

At-Risk Determination Tool

Youth or Young adults under the age of 21 may be determined to be "at-risk" if they meet the following criteria:

1. If the substance use does NOT meet the minimum criteria for a substance use disorder from the current Diagnostic and Statistical Manual (DSM) of Mental Disorders for Substance-Related Disorders (with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders);

AND

2. Determined to be at-risk of developing a substance use disorder based on reports of experimental or early-phase substance use, associated biopsychosocial risk factors, and information gathered from the full ASAM assessment and At-Risk Determination Tool (below)

Determining if Youth and Young Adult meet "at-risk" criteria for medical necessity:

Using information from the full ASAM assessment, including the DSM-5 criteria and professional judgement, complete the following table (where applicable) to identify and describe risk factors and their impact on the client's SUD risk in each of the ASAM Dimensions.

ASAM Dimension	Example of At-Risk Indicators (check all that apply)	Describe Impact on Client's SUD Risk:
Dimension 1: *Acute Intoxication and / or Withdrawal Potential*	□ Early initiation and misuse of substances: Initiation and use under 12 years of age □ Consumption: Any use of substances by youth in the past year □ Poly-substance use: Use of more than one substance, including tobacco □ Route of use: Injecting substances □ History of prior overdose □ Previous treatment for alcohol or drug use □ Other: _____ _____	
Dimension 2: *Biomedical Conditions/ Complications*	□ Chronic pain □ Other: _____ _____	
Dimension 3: *Emotional, Cognitive, Behavioral Health Conditions/ Complications*	□ Mental health issues □ Substance use to deal with mental health issues, weight issues, victimization, gang, bullying, etc. □ Other: _____ _____	

Client Name: _____
Medi-Cal: _____
Treatment Provider: _____

ASAM Dimension	Example of At-Risk Indicators (check all that apply)	Describe Impact on Client's SUD Risk:
Dimension 4: *Readiness to Change*	□ Substance use in hazardous situations (e.g., driving under the influence; use and risky sexual behaviors) □ Other: _____ _____	
Dimension 5: *Relapse / Continued Use or Problem Potential*	□ Stressors/triggers in life that contribute to substance use (e.g., pressure/issues from school, peers, family, legal) □ Other: _____ _____	
Dimension 6: *Recovery Environment (Living Situation)*	□ Friends and/or family who use substances □ Lack of social support □ Threatening relationships/situations that impact substance use □ Other: _____ _____	

At-Risk Determination Narrative:

_____

_____

_____

Youth or Young Adult is determined to be "at-risk" for developing a substance use disorder ☐ **Yes** ☐ **No**

Upon an "at-risk" determination, youth and young adults are eligible for short-term intervention services (e.g., counseling and case management) for their substance use through the EPSDT Medi-Cal benefit. These services are low-intensity, limited to 16 units of service (in 15 minute increments; totaling 4 hours), and must be provided in outpatient SUD settings.

Client Name: _____

Medi-Cal: _____

Treatment Provider: _____

SAN MATEO COUNTY ASSESSMENT TOOL- YOUTH (Paper Version)

Based on the ASAM Criteria [3rd Edition] Multidimensional Assessment

ASAM LEVEL OF CARE DETERMINATION TOOL

Instructions: For each dimension, indicate the least intensive level of care that is appropriate based on the client's severity/functioning and service needs.

ASAM Criteria Level of Care	ASAM Level	Dimension 1 Substance Use, Acute Intoxication and/or Withdrawal Potential				Dimension 2 Biomedical Condition and Complications				Dimension 3 Emotional, Behavioral, or Cognitive Condition and Complications				Dimension 4 Readiness to Change				Dimension 5 Relapse, Continued Use, or Continued Problem Potential				Dimension 6 Recovery/Living Environment			
Severity / Impairment Rating		**None (0)**	**Mild (1)**	**Mod (2)**	**Sev* (3-4)**	**None (0)**	**Mild (1)**	**Mod (2)**	**Sev (3-4)**	**None (0)**	**Mild (1)**	**Mod (2)**	**Sev (3-4)**	**None (0)**	**Mild (1)**	**Mod (2)**	**Sev (3-4)**	**None (0)**	**Mild (1)**	**Mod (2)**	**Sev (3-4)**	**None (0)**	**Mild (1)**	**Mod (2)**	**Sev (3-4)**
Early Intervention	0.5												**Consider referral to mental health facility**												
Outpatient Services	1																								
Intensive Outpatient Services	2.1																								
Partial Hospitalization Services	2.5																								
Clinically Managed Low-Intensity Residential Services	3.1																								
Clinically Managed Population-Specific High-Intensity Residential Services	3.3																								
Clinically Managed High-Intensity Residential Services	3.5																								
Medically Monitored Intensive Inpatient Services	3.7																								
Medically Managed Intensive Inpatient Services	4																								

*** Note: Withdrawal Management and Medication-Assisted Treatment (MAT) services are available for youth under 18 years of age on a case-by-case basis with SAPC approval. Please contact SAPC for further details.**

Client Name: _____

Medi-Cal: _____

Treatment Provider: _____

Placement Summary

Level of Care: Enter the ASAM Level of Care number (e.g., 1.0, 2.1, 3.1,3.5) that offers the most appropriate treatment setting given the client's current severity and functioning: _____

_____

Note: *Youth and Young Adults determined to be* ***"at-risk"*** *for a Substance Use Disorder are eligible for short-term intervention services (e.g., counseling and case management) for their substance use through the EPSDT Medi-Cal benefit. These services are low-intensity, limited to 16 units of service (in 15 minute increments; totaling 4 hours), and must be provided in outpatient SUD settings.*

Level of Care Provided: _____

If the most appropriate Level of Care is not utilized, then enter the next appropriate Level of Care and check off the reason(s) for this discrepancy with brief explanation below:

Reason for Discrepancy:

☐ Not Applicable	☐ Service Not Available	☐ Provider Judgment	☐ Client Preference
☐ Transportation	☐ Accessibility	☐ Financial	☐ Preferred to Wait
☐ Language/ Cultural Considerations	☐ Environment	☐ Mental Health	☐ Physical Health
☐ Other: _____			

Briefly Explain Discrepancy: _____

_____

Designated Treatment Location and Provider Name: _____

_____

_____

Counselor Name *(if applicable)*	**Signature**		**Date**
Licensed Eligible LPHA Name *(if applicable)*	**Signature**		**Date**
***Licensed LPHA Name**	**Signature**	**LPHA License #**	**Date**

Licensed-eligible LPHA's are psychological assistants, associate social workers (ASWs), marriage and therapy family interns (MFTI/IMFT), and professional clinical counselor intern (PCCI).

Client Name: _____
Medi-Cal: _____
Treatment Provider: _____

*A Licensed LPHA is required to sign the ASAM assessment. Licensed LPHA (Licensed Practitioner of the Healing Arts) includes: Physician, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT).

Client Name: _____

Medi-Cal: _____

Treatment Provider: _____