ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

SPECIALIZED FAMILY SUPPORT PROGRAM (SFSP)
ASSESSMENT REPORT

SFSP Assessment Report

Assessment Report Submission: The SFSP Assessment Report is complete once all of the required items listed in checklist below are gathered and submitted to the HFS for review by the SFSP Interagency Clinical Team (ICT). The SFSP Assessment Report must be submitted no later than seventy-five (75) days after an SFSP Youth's enrollment in the program. SFSP Assessment Reports must be submitted to HFS via email (HFS.CBH@illinois.gov) or fax (217-782-5672) using the subject line "SFSP Assessment Report." Completed Assessment Reports may also be mailed to the following address:

Illinois Department of Healthcare and Family Services
Attn: Bureau of Behavioral Health
Bloom Building, 3rd Floor
201 S. Grand Avenue East
Springfield, IL 62763

Assessment Report Checklist:

1. ☐ SFSP Cover Sheet (p. 3)
2. ☐ Behavioral health treatment history, covering a minimum of the last 12 months (p. 4-5)
3. ☐ Referral and Assessment Needs page (p. 6) and additional identified necessary assessments:
   - ☐ Psychological evaluation
   - ☐ American Society of Addiction Medicine (ASAM) Patient Assessment
   - ☐ Pre-Admission Screening (PAS) – Level I Screen
   - ☐ Pre-Admission Screening (PAS) – Level II Assessment and Determination Process
   - ☐ Other: ____
4. ☐ LPHA Treatment Summary and Recommendations (p. 7-8)
5. ☐ Copy of the Psychiatric Evaluation and Discharge Report/Summary from the SFSP Youth's most recent inpatient psychiatric hospitalization
6. ☐ Current Mental Health Assessment (MHA) and Individual Treatment Plan (ITP)
7. ☐ Copy of the Youth's Individual Education Plan (IEP) or 504 Plan, if applicable
8. ☐ CARES eligibility report
9. ☐ Copy of the signed SFSP Multi-Agency Consent to Disclose Confidential Information
10. ☐ Copy of the signed SFSP Parent Agreement

SFSP Assessment Report

Client Initials:
DOB:

SFSP ASSESSMENT REPORT COVER SHEET

1. GENERAL INFORMATION

Staff Name:	Staff Phone Number:	Date of First Contact:

Youth First and Last Name:	RIN:	Date of Birth:	Age:	Gender:
Address:	City:	State:	Zip Code:	County:

Race: ☐ American Indian or Alaska Native ☐ Hispanic ☐ White ☐ Asian ☐ Hawaiian Native/Other Pacific Islander ☐ Other: _____ ☐ Black/African American ☐ Multi-Race ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

US Citizen? ☐ Yes ☐ No ☐ Unknown

Primary Language:

Method of Communication: ☐ No interpreter services required ☐ American Sign Language ☐ TDD/TYY ☐ Spoken Language: _____ ☐ Other: _____

Phone: ☐ Yes ☐ No Number: _____

Insurance Coverage and Company: ☐ N/A

Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Married ☐ Domestic Partnership

Guardianship Status: ☐ Own guardian ☐ Youth in Care ☐ Biological Parent ☐ Other court appointed ☐ Adoptive Parent ☐ Other: _____

DCFS Involvement: ☐ Yes ☐ No ☐ Unknown

Household Size:

Household Income:

Living Arrangement: ☐ Homeless ☐ Residential/Institutional Setting (residential, nursing home, shelter) ☐ Independent Living ☐ Foster Care ☐ Lives with parent(s), relative(s), or guardian(s) ☐ Other: _____ ☐ State operated facility (mental health/dev. disability) ☐ Unknown ☐ Jail or correctional facility

Education Level (last completed): ☐ Pre-K/Kindergarten ☐ Grade 3 ☐ Grade 6 ☐ Grade 9 ☐ H.S. diploma/GED ☐ Bachelor's degree ☐ Grade 1 ☐ Grade 4 ☐ Grade 7 ☐ Grade 10 ☐ Some college ☐ Master's/Doctoral degree ☐ Grade 2 ☐ Grade 5 ☐ Grade 8 ☐ Grade 11 ☐ Associate's degree ☐ Unknown/Never attended

Parent/Guardian Information

First and Last Name: _____	Relationship to Client: ☐ Parent ☐ Guardian	Phone Number: _____

Address: _____	City: _____	State: _____	Zip Code: _____	County: _____

Method of Communication: ☐ No interpreter services required ☐ Spoken Language: _____ ☐ American Sign Language ☐ TDD/TYY ☐ Other: _____

Emergency Contact Information

First and Last Name: _____	Relationship to Client: _____	Phone Number: _____

Address: _____	City: _____	State: _____	Zip Code: _____

Members of Family Constellation

Name	Age	Relation to Client	Living in Home
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Established Supports	Agency	Contact Name	Phone	Email
Physician				
School/Daycare				
Counselor/Therapist				
Child Welfare Worker				
ISC/PAS Agent				
Probation Officer				
Other: _____				
Other: _____				

SFSP Assessment Report

2. BEHAVIORAL HEALTH TREATMENT HISTORY

List the mental health and substance abuse services and supports the SFSP Youth has received for at least the last 12 months, in the appropriate sections below. Attach additional pages as needed.

Assessment

Assessment Name/Type	Provider Name and Credentials	Date	Notable Results

Psychiatric Hospitalization

Hospital Name	Location (City, State)	Dates Hospitalized	Reason for Hospitalization

Residential/Group Home Treatment

Facility Name	Location (City, State)	Treatment Dates	Reason for Admission (Presenting Problem)

Adoption Preservation Services

Service Name	Provider Name	Service Frequency	Service Begin Date	Service End Date
				☐ Service ongoing
				☐ Service ongoing
				☐ Service ongoing

SFSP Assessment Report

Outpatient Mental Health Services/Supports

Service Name	Provider Name	Service Frequency	Service Begin Date	Service End Date
				☐ Service ongoing
				☐ Service ongoing
				☐ Service ongoing
				☐ Service ongoing
				☐ Service ongoing
				☐ Service ongoing
				☐ Service ongoing

Outpatient Substance Use Services/Supports

Service Name	Provider Name	Service Frequency	Service Begin Date	Service End Date
				☐ Service ongoing
				☐ Service ongoing
				☐ Service ongoing

Medication(s). Please list all of the SFSP Youth’s current and previous medications, minimally covering the past 12 months. Include all prescribed and over the counter medications.

Medication Name	Medication Purpose	Prescriber	Dosage	Date Started	Date Ended	Side Effects Experienced

SFSP Assessment Report

3.A. DIAGNOSIS

Please list all of the SFSP Youth's current diagnoses, including rule out diagnoses.

DSM-5 Diagnosis:		ICD- 10 Diagnosis:		Rule Out Diagnosis:
Diagnostic Code	DSM-5 Name	Diagnostic Code	ICD-10 Name	
_____	_____	_____	_____	☐
_____	_____	_____	_____	☐
_____	_____	_____	_____	☐
_____	_____	_____	_____	☐
_____	_____	_____	_____	☐

3.B. REFERRAL NEEDS

This section is designed to assist providers in identifying referral resources based on a Youth's presenting needs. It is not a comprehensive list of all possible referral resources to be considered.

I. Developmental Disabilities

1. Has the Youth had intellectual testing completed that demonstrates the Youth has an IQ of 70 or less? ☐ Yes ☐ No ☐ Unknown
2. Has the Youth ever been diagnosed with an Intellectual or Developmental Disability? ☐ Yes ☐ No ☐ Unknown
3. Does the Youth have a related condition that impairs the Youth's intellectual functioning or major life functioning (i.e. Autism Spectrum Disorder, Cerebral Palsy, Traumatic Brain Injury, Epilepsy, Prader Willi Syndrome). ☐ Yes ☐ No ☐ Unknown

If any of the questions in Section 3.B.I. were answered '**YES,**' link the SFSP Youth and family to the appropriate Individual Service Coordination (ISC) contracted agency.

II. Substance Use

1. Has the Youth ever been diagnosed with a Substance Use or Addictive Disorder? ☐ Yes ☐ No ☐ Unknown
2. Has the Youth used alcohol or drugs on one or more occasion in the past 90 days? ☐ Yes ☐ No ☐ Unknown
3. Does the Youth's use of alcohol of drugs (known or suspected) interfere with his/her daily life? ☐ Yes ☐ No ☐ Unknown

If any of the questions in Section 3.B.II. were answered '**YES,**' link the SFSP Youth and family to a licensed substance abuse provider.

III. Individual Care Grant (ICG) Program

1. Is the Youth less than 17 years and 6 months of age? ☐ Yes ☐ No ☐ Unknown
2. Is the Youth currently enrolled in an educational program at the elementary or high school level? ☐ Yes ☐ No ☐ Unknown
3. Does the Youth have a diagnosed mental or emotional disorder which substantially impairs the Youth's thought, perception of reality, or emotional process? ☐ Yes ☐ No ☐ Unknown

If **all** of the questions in Section 3.B.III. were answered **'YES,'** an application to the ICG program should be considered.

IV. Adoption Preservation *(If the youth is not adopted, skip to the next Section)*

1. Does the Youth's parent/guardian receive an adoption subsidy from the Illinois Department of Children and Family Services (DCFS) for the Youth?* ☐ Yes ☐ No ☐ Unknown
   - 1.a. If **'NO' or 'UNKNOWN,'** skip to the next Section.
   - 1.b. If '**YES,**' is the Youth currently receiving Adoption Preservation Services from a DCFS-contracted agency? ☐ Yes ☐ No ☐ Unknown

*The Youth and family should be linked to the designated DCFS Post Adoption Worker.

3.C. ADDITIONAL EVALUATIONS AND ASSESSMENTS RECOMMENDED BY LPHA

☐ No additional evaluations recommended

Evaluation/Assessment:	Provider Referred To:	Date Referred:	Date Assessment Completed:
☐ Psychological evaluation			
☐ ASAM Patient Assessment			
☐ PAS-Level I Screen			
☐ PAS-Level II Assessment			
☐ Other: _____			
☐ Other: _____			
☐ Other: _____			
☐ Other: _____			
☐ Other: _____			

Client Initials:
DOB:

4.A. SFSP ASSESSMENT PERIOD SUMMARY

Provide a summary of the Youth's presenting problem and needs identified during the SFSP Assessment Period. Also identify any assessments and interim services provided to the Youth and family during the SFSP Assessment Period. Include information on when the Youth was discharged from the hospital and any impact hospitalization had on the ability to link the Youth and family with services. Attach additional pages as needed.

4.B. LPHA TREATMENT RECOMMENDATIONS

This section shall only be completed by LPHA-level staff. Document the level of care and specific behavioral health services recommended for the SFSP Youth, providing an analysis and conclusion regarding the medical necessity of the services being recommended. Tie all key information about the Youth's behavioral health needs and diagnosis here. Attach additional pages as needed.

LPHA Printed Name: _____ Clinical Credentials: _____ Date: _____

Client Initials:
DOB:

4.C. SFSP OUTCOME AND AFTERCARE

A. Outcome - Please check the appropriate box(es) to indicate the Youth's treatment status as of the date of this Assessment Report. Provide additional information regarding the current status of the Youth's case in the Comments box provided.

☐ Youth and Family Linked with Recommended Ongoing Services – No Further Action Needed
☐ Referral to Recommended Ongoing Services In Process – Ongoing Case Monitoring Needed
☐ Reluctance to Engage or Participate in Follow-Up – Parent/Guardian
☐ Reluctance to Engage or Participate in Follow-Up – Youth
☐ Parent/Guardian Refusal to Participate – Case Referred to Child Welfare
☐ Youth Refusing Treatment
☐ Barriers to Ongoing Service Linkage Identified *(list in comments)*
☐ Other *(list)*: _____
☐ Conference with Interagency Clinical Team (ICT) Requested *(list reason for request in comments)*

Comments:

B. Aftercare

Identify any services, providers, and programs the Youth and family have been successfully linked with for ongoing services. Include the treatment begin date, or target begin date, for each service or program identified.

4.D. SIGNATURES

☐ RSA ☐ MHP ☐ QMHP		
Participating Staff (print name)	Signature	Date (mm/dd/yyyy)
LPHA (print name)	Signature	Date (mm/dd/yyyy)

Client Initials:
DOB:

ITEM # 5

COPY OF THE YOUTH'S MOST RECENT PSYCHIATRIC EVALUATION AND DISCHARGE REPORT/SUMMARY

Section Title Page.

Place this title page in front of the content: Psychiatric Evaluation and Discharge Report

ITEM # 6

COPY OF THE YOUTH'S CURRENT MHA AND ITP

Section Title Page.

Place this title page in front of the content: Mental Health Assessment and Individual Treatment Plan

ITEM # 7

COPY OF THE YOUTH'S CURRENT IEP OR 504 PLAN (IF APPLICABLE)

Section Title Page.

Place this title page in front of the content: IEP/504 Plan

ITEM # 8

CARES ELIGIBILITY REPORT

Section Title Page.

Place this title page in front of the content: CARES Eligibility Report

Client Initials:
DOB:

ITEM # 9

COPY OF SIGNED SFSP MULTI-AGENCY CONSENT TO DISCLOSE CONFIDENTIAL INFORMATION

Section Title Page.
Place this title page in front of the content: SFSP Multi-Agency Consents

ITEM # 10

COPY OF SIGNED SFSP PARENT AGREEMENT

Section Title Page.

Place this title page in front of the content: SFSP Parent Agreement