



Pathways to Well-Being/Intensive Services Eligibility Assessment

Please check one: INTAKE UPDATE/CHANGE PROGRAM DISCHARGE

Client Name: _____ DOB: _____

Program/Clinic Name: _____ MRN: _____

- Is the youth under the age of 21? YES NO
- Does the youth have full scope Medi-Cal? YES NO
- Does the youth meet medical necessity? YES NO
(If yes, see Assessment/Annual update ___/___/___ or Progress Note ___/___/___)

4. Is the youth currently **RECEIVING** or **BEING CONSIDERED FOR** any of the following?

| QUALIFYING SERVICES/EVENTS | YES | QUALIFYING SERVICES/EVENTS | YES |
|---|-----|--|-----|
| Special Ed, SUD, or other Health & Human Services | | Probation or other Legal Systems | |
| Therapeutic Behavioral Services (TBS) | | Wraparound/Full-Service Partnership (FSP) | |
| Specialized Foster Care Rate (ISFC, Medical, etc.) | | High-level-care Residential Settings/STRTP | |
| Psychiatric hosp. and/or DC'd w/in 90 days | | 2 or more psych. hosp. w/in 12 months | |
| 2 or more ER visits due to mental health w/in 6 months | | 2 or more placement changes for behavior w/in 24 months | |
| 2 or more antipsychotic meds at same time over 3 months | | Age 0-5 w/ more than 1 MH DX OR more than 1 psychotropic meds | |
| Age 6-11 w/ more than 2 MH DX OR more than 2 psychotropic meds | | Age 12-17 w/ more than 3 MH DX OR more than 3 psychotropic meds | |
| Received SMHS AND homeless during prior 6 months | | Intensive SMHS (In-Home Crisis, Crisis Residential Program, etc.) | |

Note: The above criteria are guidelines only and should not be used as absolutes.

(YES) ← Does the youth have an open Child Welfare case? → (NO)

| | |
|--|---|
| <p>If 1, 2, & 3 are all YES, and the youth is receiving/being considered for any service(s) in 4, then the youth meets criteria for Pathways to Well-Being (PWB).</p> <p style="text-align: center;">PATHWAYS to WELL-BEING*</p> <p style="text-align: center;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Was the youth opened/accepted for mental health services? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Regardless of eligibility, [secure] email this form to:</p> <ul style="list-style-type: none"> CFSPathway2WellBeing@ssa.ocgov.com | <p>If 1, 2, & 3 are all YES, and the youth is receiving/being considered for any service(s) in 4, then the youth meets criteria for Intensive Services (IS).</p> <p style="text-align: center;">INTENSIVE SERVICES*</p> <p style="text-align: center;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p> |
|--|---|

* If eligible for **PWB/IS**, clinician must update the **CARE PLAN** to authorize **ICC** and/or **IHBS** services.

Name of Staff Completing the Form: _____ Email: _____

Name of Assigned Clinician (if different from staff completing the form): _____

Email: _____ Program: _____ Date: _____