Ramsey County Community Human Services
Screening for Inpatient and Residential Treatment

Child's Name: _____ Date: _____

Date of Birth : _____ Rid Number: _____

Racial or Ethnic background ☐ Caucasian ☐ African-American ☐ S.E.Asian
☐ Hispanic ☐ Native-American
☐ Other _____

Worker: _____

Presenting Problem: _____

Proposed Treatment: _____

The Proposed Treatment:

1) Is medically necessary? ☐ Y ☐ N
2) Is appropriate to child's individual treatment needs? ☐ Y ☐ N
3) Can not be effectively provided in child's home? ☐ Y ☐ N
4) provides a length of stay as short as possible consistent with individual child's needs? ☐ Y ☐ N

A Diagnostic and Functional Assessment:

1) Date Complete: _____
2) ICD 9 diagnosis and code _____
3) Have been completed within last 180 days and is attached? ☐ Y ☐
4) Certify that the child meets at least one criteria for severe emotional disturbance?: ☐ Y ☐ N
5) Reflect child's current mental health status? ☐ Y ☐ N

Community Alternatives considered:	Tried and Failed	Not Sufficient to meet needs	not available or accessible
1) _____	☐	☐	☐
2) _____	☐	☐	☐
3) _____	☐	☐	☐

Parents have been consulted about this recommendation? ☐ Y ☐ N

If not, Why not? _____

Screener's Recommendation: _____

Recommendation followed?: ☐ Y ☐ N

Screener's Signature _____ Date _____

N.B: Screener must be a mental health professional who is not financially affiliated with a child treatment facility.