CARE

Client Assignment and Registration System

CARE-CUA-RDM **Child & Adolescent Uniform Assessment for Resiliency and Disease Management** (Action Code 164) Rev. 09/12

Last Name | Client ID

Suffix | Local Case Number

First Name | Component

Middle Name | Location

Assessment Type: Crisis ☐ Intake ☐ Update ☐ Discharge ☐ Referred To _____

Intake Non-Admission ■ Discharge Date ☐☐-☐☐-☐☐☐☐ (MM DD YYYY)

Referral Source _____ Reason for Discharge _____

At Risk of Placement ☐ **ED (Special Education)** ☐

Action Type: Add ___ Correct/Modify ___ Delete ___

Section 1: Child/Adolescent TRAG

(Completed by LMHA QMHP at Intake or Provider QMHP at Update)

Diagnostic Qualifier (I, E, or N) _____

A. Ohio Scales

1a. Parent Ohio Problem Severity Scale Score (0-100) _____

1b. Parent Ohio Functioning Scale Score (0-80) _____

2a. Youth Ohio Problem Severity Scale Score (0-100) _____

2b. Youth Ohio Functioning Scale Score (0-80) _____

3a. Worker Ohio Problem Severity Scale Score (0-100) _____

3b. Worker Ohio Functioning Scale (0-80) _____

B. CA-TRAG Dimension Ratings (*Complete all dimensions.)*

1. Problem Severity – Ohio Problem Severity Scale Score ■
2. Functioning – Ohio Functioning Scale Score ■
3. Risk of Self-Harm 1 2 3 4 5
4. Severe Disruptive or Aggressive Behavior 1 2 3 4 5
5. Family Resources 1 2 3 4 5
6. History of Psychiatric Treatment 1 2 3 4 5
7. Co-Occurring Substance Use 1 2 3 4 5
8. Juvenile Justice Involvement 1 2 3 4 5
9. School Behavior 1 2 3 4 5
10. Psychoactive Medication Treatment? ☐

C. Successfully Completed Service Package 1 or 2? ☐

D. Level of Care Decisions

Calculated Level of Care Recommendation (LOC-R) ■

E. LOC-D Provider Recommended Deviation _____

F. Foster Care ☐

G. TCOOMMI Consumer? ☐

H. Assessment Date ☐☐-☐☐-☐☐☐☐ (MM DD YYYY)

I. Extended Review Period Requested (*LOC-A SP 4 Only)* ☐

Assessed By: _____ **Credentials**: _____

Notes: _____

Form marked as completed by: _____

Section 2: Community Data

(Completed by Provider QMHP staff)

A. Number of Arrests in Last 30 Days: 0-96, 97 Unknown ☐

B. Attended School at any time in past 3 months 1, 2, 6 ☐

C. Primary Residence Type Last 90 Days (*Circle one*)

1 = Private Residence (Individual or Family's Own House or Apartment)
2 = Foster Care (Foster Care/Therapeutic Foster Care)
3 = Residential Care (Group Home/Assisted Living/Rehab Center)
4 = Crisis Residential
5 = Children's Residential Treatment Facility
6 = Institutional Setting (Nursing Home/Intermediate Care Facility/Hospital)
7 = Jail or Correctional Facility (Juvenile Justice/Jail/Correctional Facility)
8 = Homeless (Literally/Marginally Homeless)
9 = Other

D. Current or Highest Grade Level _____

E. Assessment Date ☐☐-☐☐-☐☐☐☐ (MM DD YYYY)

Notes: _____

Section 3: Authorized Level of Care (LOC-A)

(Completed by LMHA Utilization Management staff)

A. Actual Level of Care Authorized (LOC-A) (*Circle one*)

0 = Crisis Services
1.1 = Brief Outpatient – Externalizing
1.2 = Brief Outpatient – Internalizing
2.1 = Intensive Outpatient – Multi-Systemic Therapy
2.2 = Intensive Outpatient – Externalizing
2.3 = Intensive Outpatient – Internalizing
2.4 = Intensive Outpatient – Bipolar/Schizophrenia/Other Psychotic Disorders
4 = Aftercare
5 = Transitional Services
6 = Consumer Refuses Services
8 = Waiting for All Authorized Services
9 = Not Eligible for Services
Y = YES Waiver

B. Reasons for Deviation from LOC-R (*Check all appropriate reasons)*

Resource Limitations ☐
Consumer Choice ☐
Consumer Need ☐
Continuity of Care per UM Guidelines ☐
Other ☐

C. Authorization Date ☐☐-☐☐-☐☐☐☐ (MM DD YYYY)

Subject to Medicaid Fair Hearing ☐

Authorized By: _____ **Credentials**: _____

Notes: _____

Field Name	Type	Contents
LAST NAME	R	Individual's last name.
SUFFIX	O	Individual's last name suffix (e.g., Jr, Sr, II).
FIRST NAME	R	Individual's first name.
MIDDLE NAME	O	Individual's middle name.
CLIENT ID	O	Individual's statewide identification number.
LOCAL CASE NUMBER	R	Individual's local case number.
COMPONENT	R	Component code.
LOCATION	O/R	Location or Unit ID for Component. If a Location ID is entered, the ID must match an ID entered in the Location table in mainframe CARE.
ASSESSMENT TYPE: CRISIS	O/R	Check this box if the purpose of the assessment is to record that the person is receiving crisis services and not currently enrolled in a service package. **Note:** Crisis is no longer an Intake assessment type.
ASSESSMENT TYPE: INTAKE	O/R	Check this box if the purpose of the assessment is the individual's intake to services.
ASSESSMENT TYPE: INTAKE NON-ADMISSION	----	This option will be automatically entered by WebCARE screens if the purpose of the assessment is a non-admission due to ineligibility or refusal of services.
ASSESSMENT TYPE: UPDATE	O/R	Check this box if the purpose of the assessment is to update the person's care.
ASSESSMENT TYPE: DISCHARGE	O/R	Check this box if the purpose of the assessment is the person's discharge.
REASON FOR DISCHARGE	O/R	If discharge, indicate the code that best describes the discharge reason (A=No longer meets child criteria for services, C=Level of Care services complete, E=Elected a new provider, J=Texas Youth Commission (TYC), M=Moved out of local service area, N=Never Returned for Services within Authorized Service Period, not to exceed 90 days, P=Change in NorthSTAR provider, or Z=Other).
DISCHARGE DATE	O/R	If the assessment type is discharge, indicate the date of discharge.
REFERRED TO	O/R	Select where the person has been referred to following discharge (1=Private Practitioner, 2=Federally Qualified Health Center [FQHC], 3=Community Indigent Health Clinic, 4=Relinquishment of Custody [DFPS]-Child / Adolescents Only, 5=Residential Treatment Placement, 6=Adult Criminal or Juvenile Justice System, 7=Different Center, 8=Nursing Home, 9=No Service, 10=Unknown, 11=Other Public or Charity-based Provider).
REFERRAL SOURCE	R	Select the source that first prompted or suggested the referral (1=Family/Self, 2=School, 3=Juvenile Probation, 4=Texas Youth Commission (TYC), 5=Child Protective Services (CPS), 6=Another division within the center-MR/SA/Emergency Services, 7=MH facility, 8=Other, 9=Unknown).
AT RISK OF PLACEMENT	O/R	Check this box if the person meets ***one*** of the following: 1) history of residential/hospital placement for mental health treatment; 2) the LAR/caregiver considers residential/hospital placement for mental health treatment a solution; or 3) the child is returning from residential/hospital placement for mental health treatment. Check this box if the person meets ***at least two*** of the following: 1) history of school truancies; 2) history of serious alcohol/drug use; 3) history of serious behavioral problems at school; 4) history of delinquent behaviors in the community; 5) history of serious parental/caregiver rejections; and 6) history of serious behavioral problems at home.
ED (SPECIAL EDUCATION)	O/R	Check this box only if the person is designated special education by the school because of emotional disturbance.
ACTION TYPE: ADD	O/R	Check this line to add a new Uniform Assessment for the first time.
ACTION TYPE: CORRECT/MODIFY	O/R	Check this line to correct or modify information that has been previously submitted.
ACTION TYPE: DELETE	O/R	Check this line to delete a previously submitted form that was incorrect.

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Field Name	Type	Contents
Section 1: Child/Adolescent TRAG – *Completed by LMHA QMHP at Intake or Provider QMHP at Update.*		
DIAGNOSTIC QUALIFIER	O/R	Enter **E**(xternalizing), **I**(nternalizing), or **N**(ot yet stabilized) if the child/adolescent has been diagnosed with one of the following DSM-IV codes: 293.0; 293.81; 293.82; 295.1-295.3; 295.4; 295.6; 295.7; 295.9; 296.00-296.06; 296.24; 296.34; 296.4-296.46; 296.5-296.56; 296.6-296.66; 296.7; 296.8; 296.89; 296.9; 297.1; 297.3; 298.8; 298.9; 301.13; 309.4; or 780.09 only.
A. OHIO SCALES	R	Enter 1-100 for Problem Severity Scale score and 1-80 for Functioning Scale score. If no score, do ***not*** enter 0.
1.A. AND 1.B. PARENT SCALES	O/R	***Preferred*.** Parent responses to Ohio Scales.
2.A. AND 2.B. YOUTH SCALES	O	Individual's responses to Ohio Scales.
3.A. AND 3.B. WORKER SCALES	O/R	Use QMHP's responses only if the parent cannot or refuses to complete the scale scores.
B. CA-TRAG DIMENSION RATINGS		
1-2	D	Displays the Ohio Scores from Section 1, A. that will be used to calculate the LOC-R.
3-9	R	Indicate the individual rating for each of the Child/Adolescent-TRAG (1=No Notable Limitations to 5=Extreme Limitations).
10 PSYCHOACTIVE MED. TREATMENT?	O/R	Check this box if the consumer is receiving psychoactive medication treatment.
C. SUCCESSFULLY COMPLETED SERVICE PACKAGE 1 OR 2?	O/R	Check this box if the person has completed child/adolescent service package 1 or 2.
D. LEVEL OF CARE DECISIONS	D	Displays the Child/Adolescent-TRAG Level of Care Recommendation (LOC-R) that is automatically calculated from responses to Section 1, B.
E. LOC-D PROVIDER RECOMMENDED DEVIATION	O	Enter the clinician recommended deviation (0, 1.1, 1.2, 2.1, 2.2, 2.3, 2.4, 4, 5, Y) from LOC-R
F. FOSTER CARE	O	Check this box if child is in foster care.
G. TCOOMMI CONSUMER?	O	Check this box if the consumer receives services through a Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) contract.
H. ASSESSMENT DATE	R	Date of the Child/Adolescent TRAG completion in MMDDYYYY format.
I. EXTENDED REVIEW PERIOD REQUESTED	O/R	Used for Update assessments only. This field is completed for the small number of highly stable ongoing individuals in Service Package 4 who are not scheduled to see a provider for another 180 days. You *cannot* complete this field for people receiving their first Uniform Assessment at Intake.
ASSESSED BY	R	Name of the person completing Section 1.
CREDENTIALS	R	Highest credentials of the person completing Section 1 (QMHP-CS, RN, LCSW, LMSW-ACP, LMFT, LPC, LPHD-Psy, RN-APN, PA, MD, DO). LVN is not approved to complete Section 1.
NOTES	O	Used for provider/authority communication and clinical notes. Limited to 6 lines or less.
Section 2: Community Data – *Completed by Provider QMHP staff.*		
A. NUMBER OF ARRESTS IN LAST 30 DAYS	R	Values are 0-96, 97=Unknown
B. ATTENDED SCHOOL AT ANY TIME IN PAST THREE MONTHS	R	1 = YES; 2 = NO; 6 = NOT APPLICABLE
C. PRIMARY RESIDENCE TYPE DURING THE LAST 90 DAYS	R	Indicate the primary residence type for the person during the last 90 days. If **8** (Homeless), the following applies: **Literally Homeless**: Those who are actually without shelter, except for emergency shelter provided by such organizations as the Salvation Army. Literally homeless people are most frequently found in shelters or on the streets. **Marginally Homeless**: Those who are at imminent risk of becoming homeless. A marginally homeless person is in a temporary living situation that is unstable or is about to be terminated, causing the person to be literally homeless.

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Sections, Continued

Field Name	Type	Contents
D. CURRENT OR HIGHEST GRADE LEVEL	R	00 NO YEARS IN SCHOOLING, 01 GRADE 1, 02 GRADE 2, 03 GRADE 3, 04 GRADE 4, 05 GRADE 5, 06 GRADE 6, 07 GRADE 7, 08 GRADE 8, 09 GRADE 9, 10 GRADE 10, 11 GRADE 11, 12 GRADE 12 OR GED, 13 NURSERY SCHOOL, PRE-SCHOOL INCLUDING HEAD START, 14 KINDERGARTEN, 15 SELF CONTAINED SPECIAL EDUCATION, 16 VOCATIONAL, 17 COLLEGE UNDERGRADUATE FRESHMAN, 18 COLLEGE UNDERGRADUATE SOPHOMORE, 19 COLLEGE UNDERGRADUATE JUNIOR, 20 COLLEGE UNDERGRADUATE SENIOR, 21 GRADUATE OR PROFESSIONAL SCHOOL, 97 UNKNOWN AND 99 NOT COLLECTED.
F. ASSESSMENT DATE	R	Date the community data was collected in MMDDYYYY format.
NOTES	O	Used for the name and credentials of the staff responsible for completion of this section or for provider/authority communication. Limited to 6 lines or less.

Section 3: Authorized Level of Care (LOC-A) – *Completed by LMHA Utilization Management staff.*

A. ACTUAL LEVEL OF CARE AUTHORIZED	R	Indicate the actual Level of Care Authorized (LOC-A) by your facility for this child/adolescent.
B. REASONS FOR DEVIATION FROM LOC-R	R	If LOC-A is different from LOC-R, check the box next to every applicable reason for the deviation.
C. AUTHORIZATION DATE	R	The date the LOC-A becomes effective in MMDDYYYY format. This section *must* be completed within 30 days of the Section 1 Assessment Date.
SUBJECT TO MEDICAID FAIR HEARING	O/R	This box should only be checked when the effective date of a level of care has been delayed because the person is: (1) Medicaid eligible, (2) the new level of care authorized will result in a reduction in either rehabilitative services or case management services, and (3) the individual is within the 10 to 14-day notification period specified by the Medicaid Fair Hearing requirements.
AUTHORIZED BY	R	Name of the person who authorized the LOC-A.
CREDENTIALS	R	Highest credentials of the person completing Section 3 (QMHP-CS, RN, LCSW, LMSW-ACP, LMFT, LPC, LPHD-Psy, RN-APN, PA, MD, DO). LVN is *not* approved to complete Section 3.
NOTES	O	Used for provider/authority communication and clinical notes. Limited to 6 lines or less.
FORM MARKED AS COMPLETED BY:	O/R	Signature of the person indicating the form is complete (“Complete” or “Provider Complete”).