CENS
Client Engagement and Navigation Services

YOUTH SCREENER

Date:_____	Start time:_____	Stop time:_____	Total completion time:

Thank you for calling the Los Angeles County Substance Abuse Service Helpline (SASH).

1. **How did you hear about us?**
   ☐ Website ☐ Family/Friend
   ☐ Provider ☐ Other agency (_____)

2. **Are you calling regarding service information for youth under the age of 18?**
   ☐ Yes (If YES, proceed to next question)
   ☐ No (If NO, proceed to adult prompt/Brief Triage Assessment)

3. **Are you calling for yourself or on behalf of someone else?**
   ☐ Self / Youth ☐ Parent/Guardian of Child ☐ SUD Provider for patient/client ☐ Court / Probation officer

   ☐ Other _____

(If caller is a parent or guardian seeking services for a youth, use the parent screener screening is not applicable for other types of caller such as SUD provider or court/probation officer.)

Youth Demographic information					
Youth Name:			**Phone Number:** ☐ Mobile **Okay to leave voicemail?** ☐ Yes ☐ No		
Parent / Guardian Name:					
Address or Zip Code:					
DOB:	**Age:**		**Gender:**		
Race/Ethnicity:	**Preferred Language:**		**Medi-Cal or MyHealthLA ID #:**		
Insurance Type: ☐ None	☐ MyHealthLA	☐ Medicare (plan):	☐ Medi-Cal (plan):	☐ Private (plan):	☐ Other (specify):
Living Arrangement: ☐ Homeless	☐ Living with family	☐ Living in foster care	☐ Other (specify):		
Referred by (specify):					

4. **What are the main reasons you are seeking help today?**

5. **Are you currently receiving other services such as physical or mental health counseling?** Please describe.

6. **Are you currently experiencing any family, financial, legal, or school problems?** Please describe.

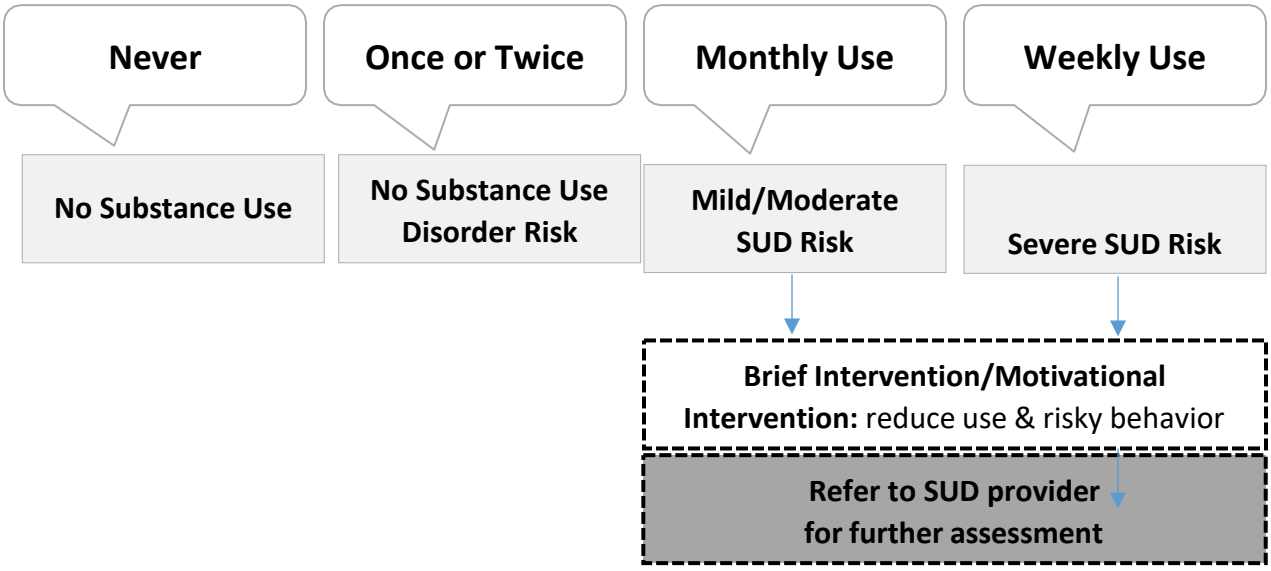
S2BI: Screening to Brief Intervention

In the past year, how many times have you used [X]?	Never	Once or Twice	Monthly	Weekly
1. Tobacco Products	☐	☐	☐	☐
2. Alcohol	☐	☐	☐	☐
3. Marijuana	☐	☐	☐	☐
4. Illegal Drugs (i.e. cocaine or Ecstasy)	☐	☐	☐	☐
5. Prescription drugs that were not prescribed for you (i.e. Pain Medication or Adderall)	☐	☐	☐	☐
6. Inhalants (i.e. nitrous oxide)	☐	☐	☐	☐
7. Herbs or synthetic drugs (i.e. salvia, K2, or bath salts)	☐	☐	☐	☐

Client Name:_____ Medi-Cal or My Health LA ID:_____

Treatment Provider: _____

S2BI Algorithm



Thank you for answering these questions. Based on what you shared, we would like to connect you to an agency in your local community (near you) for a further assessment and information about services to assist with your needs. How doesthat sound?

Referral Information:

Agency Name:

_____

_____

Address:_____

_____

_____

Phone:_____

_____

_____

Appointment Date/ Time (if available): _____

Placement Summary

Level of Care Assessment: All youth are to be referred to the closest youth services agency for full ASAM assessment. However, youth who are just exiting residential- of hospital-based withdrawal management and those who are being referred to residential treatment from an outpatient program should be referred to a residential program for assessment.

Designated Assessment Location and Provider Name:

_____

_____

_____

Staff/Clinician Name: **Signature:** **Date:**

Supervisor Name: **Signature:** **Date:**

Client Name:_____ Medi-Cal or My Health LA ID:_____

Treatment Provider: _____