



Mat-Su Pilot Project
Bring/Keep the Kids Home
Diversion Criteria Checklist

Client Information

Client Name: _____ DOB: _____

Address: _____

Telephone: _____ Cell: _____

Parent's Names: _____

Timing

Yes No

 1. Has there been a previous serious consideration of referral to increased level of care beyond level 3?

 2. Is there a multiple discipline agreement that the next step will include a referral of care beyond level 3?

 3. Is there an existing but pending referral to increase level of care beyond level 3 by one of the following:

Behavioral Health clinician and/or team

Medical Physician

Law enforcement/Justice Personnel

 4. Has the client ever been in residential treatment or acute hospitalization?

If so, when? From: _____ To: _____

Where at? _____

Notes:

DSM Diagnostics

Which of the following diagnoses does the client have?

- | | |
|---|--|
| <input type="checkbox"/> Schizophrenic Spectrum Disorders | <input type="checkbox"/> Bipolar |
| <input type="checkbox"/> Agitated Depression | <input type="checkbox"/> OCD |
| <input type="checkbox"/> PTSD | <input type="checkbox"/> Aggressive ADHD |
| <input type="checkbox"/> Disruptive Disorders | <input type="checkbox"/> Borderline/Cluster B features |
| <input type="checkbox"/> Learning Disabilities | <input type="checkbox"/> Substance Abuse Disorders |
| <input type="checkbox"/> Pervasive Development Disorder NOS | <input type="checkbox"/> Autistic Spectrum Disorders |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

Other non DSM considerations:

- | | |
|---|---|
| <input type="checkbox"/> FASD | <input type="checkbox"/> Traumatic Brain Injury |
| <input type="checkbox"/> Borderline Intellectual Functioning with Behavior Problems | |

Functional Assessment

Place an "X" next to the behaviors that are demonstrated by the client on a consistent or repeated basis.

Academic:

- | | |
|---|--|
| <input type="checkbox"/> Failing Classes | <input type="checkbox"/> Serious disruptions |
| <input type="checkbox"/> Suspensions due to aggression or Violence | <input type="checkbox"/> Isolation |
| <input type="checkbox"/> Forced school change or alternative school | <input type="checkbox"/> Truancy/Tardiness |

Home:

- | | |
|---|---|
| <input type="checkbox"/> Destruction of property | <input type="checkbox"/> Run away behaviors |
| <input type="checkbox"/> Aggressive/violent behaviors | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Threats or threatening behaviors | <input type="checkbox"/> Family: _____ |

Community:

- | | |
|---|---|
| <input type="checkbox"/> Involvement with OCS/DJJ | <input type="checkbox"/> Multiple placements |
| <input type="checkbox"/> Destruction of property | <input type="checkbox"/> Criminal activity/thinking |
| <input type="checkbox"/> Aggressive/violent behaviors | |

Personal:

- | | |
|--|--|
| <input type="checkbox"/> Inability to maintain hygiene | <input type="checkbox"/> Eating disordered behaviors |
| <input type="checkbox"/> Inability to perform daily living tasks | <input type="checkbox"/> Destruction of personal items |
| <input type="checkbox"/> Pervasive developmental deficits | <input type="checkbox"/> Trauma History |
| <input type="checkbox"/> Self-harm | |

If the client meets all of the following criteria they can be referred for Diversion services.

- | <u>Yes</u> | <u>No</u> | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Did you answer 'yes' to any question numbers 1-4? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does the client have any of the previously listed diagnoses? |
| <input type="checkbox"/> | <input type="checkbox"/> | Does the client show significant deficits in the previously listed functional criteria? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has the client had an evaluation by either a psychiatrist or psychologist in the past year?
If so, when? _____ By whom? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the client actively involved in community or other mental health services?
With which agency? _____ |

Notes:

Referral Process:

- Complete a Release of Information for Co-Occurring Disorders Institute – CoDI
- Fax completed Diversion Checklist to CoDI at 907-745-4897
- Provide the referral family/client with contact information for CoDI:
Co-Occurring Disorders Institute
7335 E. Palmer/Wasilla Highway, Suite 2C
Wasilla, AK 99654
(907) 745-2634
- Families can then contact CoDI directly for a screening and intake
- Agencies with custody such as DJJ and OCS can make referrals directly to CoDI without prior consent
- Client will then be presented to the Workgroup if they meet Diversion eligibility criteria