

AspireMN
DISCHARGE FORM

Child Demographics

1. AspireMN AGENCY NO.

2. CHILD/CLIENT NO.

3. End Service Date: ____-____-____
Month Day Year

4. Is the child's primary household the same as at admission?

Yes

No



What is the child's primary household now (V one)?

Single/Sole Caregiver Households (select one of the following)

One Birth Parent

One Adoptive Parent

One Foster Parent

One Relative Caregiver

Dual Caregiver Households (select one of the following)

Married/partnered Birth Parents

One Birth Parent with Step Parent or Non-Birth Parent Partner

Married/Partnered Adoptive Parents

One Adoptive Parent with Step Parent or Non-Birth Parent Partner

Married/Partnered Foster Parent

Married/Partnered Relative Caregiver

No Permanent Living Situation

5. Indicate the child's grade level at DISCHARGE:

K 1 2 3 4 5 6 7 8 9 10

11 12 GED Enroll Grad/GED Not Available

Health and Safety

6. Indicate any current mental health diagnosis of the child at discharge:

	Intake DX	Discharge DX
Primary DX:		<input type="checkbox"/> No Change <input type="checkbox"/> Submit New Entry
Secondary DX:		<input type="checkbox"/> No Change <input type="checkbox"/> Submit New Entry
Other (please specify):		<input type="checkbox"/> No Change <input type="checkbox"/> Submit New Entry
	<input type="checkbox"/> N/A	<input type="checkbox"/> No Change <input type="checkbox"/> Submit New Entry

7. Has the health status of the child changed since intake in any of the areas provided (✓ only new information not given at intake) Yes No (Skip to Next)

- Pregnancy (Current)
- Pregnancy (Past)
- Prenatal drug
- Obese
- Asthma
- Diabetes
- Physical disability/limitation
- Seizure disorder
- Neurological impairment
- Auditory impairment
- Other (please specify): _____
- Suspected but not confirmed physical health condition
- No concerns

8. While receiving services from your agency, have there been any new findings of maltreatment by caregivers? (✓ all maltreatment (one per row) experienced by the child while receiving services from your agency)

	None Known or Suspected	Suspected/Not Documented	Documented
A. Emotional Abuse/Neglect			
B. Physical Abuse			
C. Physical Neglect (food, medical care, etc.)			
D. Sexual Abuse			
E. Witness to domestic violence			
F. Victim of Sex Trafficking or Exploitation			

9. Has an adoption of the child been legally finalized while receiving services from this agency?

- Yes No

10. Is the child a ward of the state?

- Yes No

11. Since intake has the child been arrested or charged for:

				If yes, was this a felony?
Crime against persons	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Crime against property	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Other (please specify): _____				

Services and Treatment

12. Therapeutic Services/Treatment

12a. What therapeutic services did the child/family receive during the service episode (v all that apply)	Therapeutic Services/Treatment
<input type="checkbox"/>	CBT
<input type="checkbox"/>	DBT
<input type="checkbox"/>	TFCBT
<input type="checkbox"/>	EMDR
<input type="checkbox"/>	Family Therapy
<input type="checkbox"/>	Relationship Therapy (Patient/Caregiver)
<input type="checkbox"/>	Individual Therapy
<input type="checkbox"/>	Psychoeducation
<input type="checkbox"/>	Medication management
<input type="checkbox"/>	Substance Use Education
<input type="checkbox"/>	Sex Offender Therapy
<input type="checkbox"/>	Crisis Hospitalization (psychiatric)
<input type="checkbox"/>	Group Therapy
<input type="checkbox"/>	Play Therapy
<input type="checkbox"/>	Eating Disorders Therapy
<input type="checkbox"/>	Chemical Dependency Tx
<input type="checkbox"/>	Occupational Therapy
<input type="checkbox"/>	Other (please specify): _____ _____

13. Medical Services

13a. What medical services did the child receive during the service episode (v all that apply)	Medical Services
<input type="checkbox"/>	

<input type="checkbox"/>	Corrective Surgery
<input type="checkbox"/>	Vision
<input type="checkbox"/>	Hearing
<input type="checkbox"/>	Routine Dental
<input type="checkbox"/>	Orthodontic
<input type="checkbox"/>	Neurological
<input type="checkbox"/>	Dermatology
<input type="checkbox"/>	Orthopedic
<input type="checkbox"/>	OB/GYN
<input type="checkbox"/>	Routine Physical
<input type="checkbox"/>	Physical Therapy
<input type="checkbox"/>	Psychiatric
<input type="checkbox"/>	Psychological testing
<input type="checkbox"/>	None
<input type="checkbox"/>	Other(please specify): _____
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____

14. Skill Development Services

14a. What skill development services did the child/family receive during the service episode (√ all that apply)	Skill Development Services
<input type="checkbox"/>	Self-help skills/ daily living skills
<input type="checkbox"/>	Independent living skills
<input type="checkbox"/>	Recreational/leisure skills
<input type="checkbox"/>	Emotional/social skills
<input type="checkbox"/>	Employment training
<input type="checkbox"/>	Family skills services
<input type="checkbox"/>	Parenting Skills
<input type="checkbox"/>	None

15. Current school related services (√ all that apply)

<input type="checkbox"/> IEP
<input type="checkbox"/> 504 Plan
<input type="checkbox"/> School linked mental health services
<input type="checkbox"/> Truancy Services/Intervention
<input type="checkbox"/> No school related problems or services
<input type="checkbox"/> Other (please specify): _____

16. Community involvement

Community Involvement	16b. What community activities was the child/family involved in during the service episode (√ all that apply)
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Youth Groups	<input type="checkbox"/>
Volunteer Work	<input type="checkbox"/>
Restitution programs	<input type="checkbox"/>
Restorative justice programs	<input type="checkbox"/>
Community recreation/athletic programs	<input type="checkbox"/>
Special Olympics	<input type="checkbox"/>
Church groups	<input type="checkbox"/>
Summer camp/wilderness retreat	<input type="checkbox"/>
Other	<input type="checkbox"/>
None	<input type="checkbox"/>

17. Family/social worker/probation officer (P.O) involvement. Please V the rating that best fits the level of involvement for these parties.

17a. How involved with the child during care was the:	Very Uninvolved	Uninvolved	Minimally Involved	Involved	Very Involved	N/A
Family	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
Social Worker/P.O	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
17b. How supportive of the child's program was the:	Very Uninvolved	Uninvolved	Minimally Involved	Involved	Very Involved	N/A
Family	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
Social Worker/P.O.	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9

Discharge and Plan

18. Were the treatment plan goals completed?

Yes No

Commented [MR1]: Suggestion to change to question like "To what extent were treatment plan goals completed?" with a scale

19. The discharge was initiated by (V one):

<input type="checkbox"/> Agency foster parent	<input type="checkbox"/> Child/runaway
<input type="checkbox"/> Treatment program	<input type="checkbox"/> Parent
<input type="checkbox"/> Court	<input type="checkbox"/> Health Plan
<input type="checkbox"/> County Social Worker/P.O.	<input type="checkbox"/> Other (please specify): _____

20. Indicate the post-discharge living arrangement following tx completion (v one)	Living situations
	Parent(s) home
	Living independently
	Pre-adoptive placement
	Homeless shelter (youth only)
	Transitional living program
	Relative placement
	Foster care home
	Group home
	Shelter or shelter foster care
	Inpatient psychiatric facility or hospital
	Residential treatment program
	a. Chemical Dependency (CD)
	b. Dual DX (Mental Illness/CD)
	c. Sex offender treatment (SO)
	d. MHH (non-SO)
	e. Corrections (non-SO)
	Unknown living arrangement

20. Indicate the post-discharge living arrangement following tx completion (v one)

21b. IF NO, indicate the post-discharge living arrangement recommended by your agency (from question 20 above).	Living situations
	Parent(s) home
	Living independently
	Pre-adoptive placement
	Homeless shelter (youth only)
	Transitional living program
	Relative placement
	Foster care home
	Group home
	Shelter or shelter foster care
	Inpatient psychiatric facility or hospital
	Residential treatment program (v one):
	a. Chemical Dependency (CD)
	b. Dual DX (Mental Illness/CD)
	c. Sex offender treatment (SO)
	d. Mental Health (non-SO)
	e. Corrections (non-SO)
	Unknown living arrangement

21. Was the living arrangement recommended by your agency?

Yes

No

22. What is the school plan for this child? (V one)

- Public/private school
- Technical/vocational school
- Day treatment including education program
- Other
- Completed school/GED
- No school plan
- Unknown

23. What is the occupational plan for this child? (V one)

- Full-time employment
- Part-time employment
- Temporary work
- Other
- No employment plan
- Unknown
- N/A

Overall Assessment Post-discharge

Please enter the POST_DISCHARGE scores for the same assessments completed and entered at INTAKE.

24. Strengths and Difficulties Questionnaire

SUBSCALE SCORES

- A. Emotional Symptoms: _____
- B. Conduct Problems: _____
- C. Hyperactivity/inattention: _____
- D. Peer Relationship Problems: _____
- E. Prosocial Behavior: _____
- COMPOSITE: _____

25. Child and Adolescent Needs and Strengths Assessment

SUBSCALE SCORES

- A. Life Domain Functioning: _____
- B. School: _____
- C. Child Behavioral/Emotional Needs: _____
- D. Child Risk Behaviors: _____
- E. Cultural Considerations: _____
- F. Transition to Adulthood: _____
- G. Child Strengths: _____
- H. Caregiver Resources and Needs: _____
- COMPOSITE: _____

26. Early Childhood Service Intensity Instrument

SUBSCALE SCORES

Commented [AB2]: All items should be completed except Transition to Adulthood items if the child is under 14 ½ y.o.) There is an Incomplete but Final option and the person must give reason for inability to complete. The CANS is updated at the time of each tx plan review. There is a comment field that follows each section where the worker may clarify any item responses and add contextual information.

- A. Degree of Safety: _____
- B. Child Caregiver Relationships: _____
- C. Caregiver Environment: _____
 - 1c. Strengths/Protective Factors: _____
 - 2c. Stressors/Vulnerabilities: _____
- D. Functional Developmental Status: _____
- E. Impact of the Child's Medical, Developmental, and Emotional/Behavioral Problems: _____
- F. Services Profile: _____
- COMPOSITE: _____

27. Child and Adolescent Service Intensity Instrument (CASII)

SUBSCALE SCORES

- A. Risk of Harm: _____
- B. Functional Status: _____
- C. Co-occurrence of Condition: _____
- D. Recovery Environment: _____
- E. Resiliency and/or Response to Services: _____
- F. Involvement in Services (Child or Adolescent): _____
- G. Involvement in Services (Parent and/or Primary Care Taker): _____
- COMPOSITE: _____

28. Youth Level of Service Inventory

SUBSCALE SCORES

- A. Prior and Current Offenses: _____
- B. Education: _____
- C. Substance Abuse: _____
- D. Family: _____
- E. Personality/Behavior: _____
- F. Peers: _____
- G. Leisure/Recreation: _____
- H. Attitudes/Orientation: _____
- COMPOSITE: _____

29. Problem Oriented Screening Instrument for Teenagers (POSIT)

SUBSCALE SCORES

- A. Substance Abuse/Use: _____
- B. Physical Health Status: _____
- C. Mental Health Status: _____
- D. Family Relationships: _____
- E. Peer Relations: _____
- F. Educational Status: _____
- G. Vocational Status: _____
- H. Social Skills: _____
- I. Leisure/Recreation: _____
- J. Aggressive Behavior/Delinquency: _____

Strengths/Assets Assessment Post-discharge

Please enter the POST-DISCHARGE scores for at least one scale in the strengths/assets category.

30. Developmental Assets Scale

- A. External Support: _____
- B. Empowerment: _____
- C. Boundaries and Expectations: _____
- D. Constructive Use of Time: _____
- E. Internal Commitment to Learning: _____
- F. Positive Values: _____
- G. Social Competencies: _____
- H. Positive Identity: _____
- COMPOSITE: _____

31. Youth Connections Scale

SUBSCALE SCORES

- A. Tools for Youth Connections: _____
- B. Number of Supportive Adult Connections: _____
- C. Strength of Youth Connections: _____
- D. Support Indicators: _____
- E. Level of Youth Connections: _____
- COMPOSITE: _____

Trauma Assessment Post-discharge

Please enter the POST-DISCHARGE scores for at least one scale in the trauma assessment category.

32. Trauma Symptom Checklist for Young Children Scale

SUBSCALE SCORES

Caretaker report validity scales

- A. Response Level (RL): _____
- B. Atypical Response (ATR): _____

Clinical Scales

- A. Posttraumatic Stress – Intrusion (PTS-I): _____
- B. Posttraumatic Stress – Avoidance (PTS-AV): _____
- C. Posttraumatic Stress – Arousal (PTS-AR): Posttraumatic Stress: _____
- D. Posttraumatic Stress – Total (PTS-TOT): Posttraumatic Stress: _____
- E. Anxiety (ANX): _____
- F. Dissociation (DIS): _____
- G. Anger/Aggression (ANG): _____
- COMPOSITE: _____

33. Trauma Symptom Checklist for Children Scale

SUBSCALE SCORES

- A. Anxiety: _____
- B. Depression: _____
- C. Posttraumatic Stress: _____
- D. Sexual Concerns: _____
- E. Dissociation: _____
- F. Anger: _____
- COMPOSITE: _____

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