



**SUBSTANCE ABUSE PREVENTION & CONTROL
ASAM SCREENER FOR YOUTH & YOUNG ADULTS**

Attachment I

The ASAM Screener for Youth and Young Adults must be used to document eligibility for Early Intervention services for youth young adults (ages 20 and under) as described in bullet 2 of the eligibility information below:

Eligibility for SUD Services for Individuals Aged 20 and Under:

1) **SUD Treatment Services** *(Requires: Assessment Tool-Youth (Ages 17 and under) or Full ASAM Assessment (18-20))*
Meet criteria for at least one diagnosis from the current DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders.

OR

2) **Early Intervention Services**
(Requires: ASAM Screener for Youth and Young Adults (Ages 20 and under))
Meet Early and Periodic Screening, Diagnostic and Treatment (EPSDT) criteria to ameliorate or correct a substance related condition, with the exception of tobacco-related conditions and non-substance related conditions.

Youth/Young Adult Demographic information				
Youth/Young Adult Name:	Date:	Phone Number:	<input type="checkbox"/> Mobile	
Okay to leave voicemail. <input type="checkbox"/> Yes <input type="checkbox"/> No				
Parent / Guardian Name (for youth 17 and under):				
Address or Zip Code:				
DOB:	Age:	Gender:		
Race/Ethnicity:	Preferred Language:	Medi-Cal ID #:		
Other ID# (Plan):				
Insurance Type: <input type="checkbox"/> None <input type="checkbox"/> Medicare <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Private <input type="checkbox"/> Other				
(plan): _____ (plan): _____ (plan): _____ (plan): _____				
Living Arrangement: <input type="checkbox"/> Homeless <input type="checkbox"/> Living with family <input type="checkbox"/> Living in foster care <input type="checkbox"/> Other (specify):				
Referred by (specify):				

1. What are the main reasons you are seeking help today?

2. Which other services, such as physical or mental health counseling, are you receiving? Please describe.

3. Which family, financial, legal, or school problems are you experiencing? Please describe.

<p><small>This confidential information is provided to you in accord with State and Federal and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code, HIPAA Privacy Standards, and 42 CFR Part 2 Confidentiality of Substance Use Disorder Patient Records. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.</small></p>	<p>Patient Name: _____ Medi-Cal CIN: _____</p> <p>Treatment Provider: _____</p> <p>Treatment Provider Site: _____</p>
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EPSDT Eligibility Criteria for Early Intervention Services for Youth and Young Adults:

Screen patient using the following six ASAM dimensions to identify SUD risk factors. Patient must be determined to have one or more risk factors to meet EPSDT criteria for Early Intervention Services. Note: Consideration of SUD risks must take into account all six dimensions, as interaction among the dimensions may increase or decrease their SUD risk. Some SUD risk may require the presence of multiple risk factors among the dimensions. (See Guidance for Completing the ASAM Screener for Youth and Young Adults for more detailed instructions).

ASAM Dimension	Example of At-Risk Indicators (check all that apply)
<p>Dimension 1: <i>Acute Intoxication and/or Withdrawal Potential</i></p>	<p>Have you experienced any of the following?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Any past year substance use (complete table on page 3) <input type="checkbox"/> Early initiation and misuse of substances (under 12 years of age) <input type="checkbox"/> Route of use: Injecting substances <input type="checkbox"/> History of prior overdose <input type="checkbox"/> Previous treatment for alcohol, tobacco/nicotine, or drug use <input type="checkbox"/> Other: _____
<p>Dimension 2: <i>Biomedical Conditions / Complications</i></p>	<p>Do you have any medical/physical health condition(s) we should know about?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Chronic pain <input type="checkbox"/> Asthma <input type="checkbox"/> Diabetes <input type="checkbox"/> Pregnancy <input type="checkbox"/> HIV/AIDS, other sexually transmitted infection <input type="checkbox"/> Other: _____
<p>Dimension 3: <i>Emotional, Cognitive, Behavioral Health Conditions / Complications</i></p>	<p>Have you experienced any depression, anxiety, or other mental health issues?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Compulsive behavior <input type="checkbox"/> ADHD (Attention Deficit Hyperactivity Disorder) <input type="checkbox"/> PTSD (Post Traumatic Stress Disorder) <input type="checkbox"/> Other Mental health issues: _____
<p>Dimension 4: <i>Readiness to Change</i></p>	<p>Thinking about the effects of substance use, which area(s) of your life is most impacted by alcohol or other drug use?</p> <ul style="list-style-type: none"> <input type="checkbox"/> School <input type="checkbox"/> Work <input type="checkbox"/> Personal Relationships (Family/Friends/Romantic Partners) <input type="checkbox"/> Hobbies/Recreation <input type="checkbox"/> Other: _____ <p>Do you think you need treatment services to help change your use of substances?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes <input type="checkbox"/> No, it is not a problem. <input type="checkbox"/> No, I can stop anytime without help. <input type="checkbox"/> I don't know

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<p>Dimension 5: <i>Relapse / Continued Use or Problem Potential</i></p>	<p>Are there any particular situations or stressors that would make you want to use?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cravings, withdrawal symptoms, or negative effects of substance use <input type="checkbox"/> Social Pressure (friends/partners, families, at school, at work, at home) <input type="checkbox"/> Triggers, including managing feelings/emotional stressors (trauma, sexual/gender identity, anxiety, depression, boredom, anger, etc.) <input type="checkbox"/> Other: _____ <p>At this time, which stressor(s) above are most problematic for you?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Stressor: _____
<p>Dimension 6: <i>Recovery Environment (Living Situation)</i></p>	<p>Do you currently live in an environment where others are regularly using drugs or alcohol?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Friends and/or family who use substances <p>Which situations in your life that make not using substances or cutting back substance use more difficult?</p> <ul style="list-style-type: none"> <input type="checkbox"/> Lack of social support <input type="checkbox"/> Threatening relationships (gang, bullying, victimization) <input type="checkbox"/> Unstable housing / homelessness <input type="checkbox"/> Academic difficulty <input type="checkbox"/> Criminal-legal system involvement (such as juvenile hall and/or jail/prison) <input type="checkbox"/> Other: _____

Past Year Substance Use:

Complete the following screening of past year substance use (based on the [S2BI tool](#)):

<i>In the past year, how many times have you used the substance(s) listed below?</i>	Never	Once or Twice	Monthly	Weekly or More
1. Tobacco Products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Marijuana	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Illegal Drugs <i>(e.g., heroin, fentanyl, cocaine, methamphetamine, and Ecstasy)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Prescription drugs that were not prescribed for you <i>(e.g., Pain Medication such as Vicodin or Percocet, Sedatives such as Valium or Xanax, or Stimulants like Ritalin or Adderall)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Inhalants <i>(e.g., nitrous oxide)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Herbs or synthetic drugs <i>(e.g., salvia, K2, or bath salts)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Narrative of Patient's Substance Use Risks:

Describe the patient's risk for SUD by summarizing their risk factors among the ASAM dimensions. Consideration for SUD risks must take into account all six ASAM dimensions, as interactions among the dimensions may increase or decrease their SUD risk. (See Guidance for Completing the ASAM Screener for Youth and Young Adults for more detailed guidance around assessing for SUD risk).

Youth/Young Adult is determined to meet eligibility criteria for Early Intervention services: Yes No

Did the patient complete a Full ASAM Assessment: Yes No

ASAM Assessment Date: _____

Risk Information

If the result of the ASAM Screener for Youth and Young Adults indicates that the Youth/Young Adult meets EPSDT criteria for Early Intervention services, they should be enrolled into Early Intervention Services (ASAM 0.5) to ameliorate or correct a substance misuse related condition. A full ASAM Assessment is required to enroll patients into higher intensity levels of care (e.g., ASAM 1.0, 2.1, 3.1, WM, etc.).

Designated Treatment Location/Referral Information:

Agency Name: _____

Address: _____

Phone: _____

Appointment Date/ Time (if available): _____

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

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 Treatment Provider: _____
 Treatment Provider Site: _____