



## LOS ANGELES COUNTY ASSESSMENT TOOL- YOUTH (Paper Version)

Based on the ASAM Criteria [3<sup>rd</sup> Edition] Multidimensional Assessment

Demographic information			
Name:	Date:	Phone Number:	<input type="checkbox"/> Mobile
		Okay to leave text or voicemail? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Address:			
Date of Birth:	Age:	Gender:	
Race/Ethnicity:	Preferred Language:	Medi-Cal or My Health LA ID #:	
		Other ID# (Plan):	
Insurance Type:	<input type="checkbox"/> None	<input type="checkbox"/> My Health LA	<input type="checkbox"/> Medicare
		<input type="checkbox"/> Medi-Cal	<input type="checkbox"/> Private
		<input type="checkbox"/> Other	
	(Plan):	(Plan):	(Plan):
Parent/Legal Guardian:		Relationship:	
Living Arrangement: <input type="checkbox"/> Parent/Legal Guardian <input type="checkbox"/> Independent Living <input type="checkbox"/> Homeless <input type="checkbox"/> Agency/Other (specify):			
Referred by: <input type="checkbox"/> Foster/DCFS <input type="checkbox"/> Probation <input type="checkbox"/> Family <input type="checkbox"/> Self <input type="checkbox"/> Other (specify):			
Please list all current health providers (physicians, clinicians, therapists, or counselors):			
Name	Type of Provider	Contact Information	
Please list all current medication(s) and/or herbal supplements:			
Medication	Dose/Frequency	Duration	Reason

**Explanation of why client is currently seeking treatment** - Current symptoms, functional impairment, severity, duration of symptoms, other issues (e.g., unable to work/go to school, relationship issues, housing problems):

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## Dimension 1: Substance Use, Acute Intoxication, Withdrawal Potential

### 1. Substance Use History:

DSM-5 Substance-Related Disorders	Lifetime Use	Age First Use	Past Year Use	Past Year Duration	Amount of Current Use	Frequency	Route of Use	Date of Last Use
			Use in past year (If none, proceed to next illicit drug. No need to complete remaining items in row)	# months past year	Use in last month	Daily, weekly, monthly, Etc.)		
Alcohol	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Cannabis (Marijuana)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Hallucinogens	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Inhalants	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Opioid: Heroin	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Opioid: Pain Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Sedatives, Hypnotics, or Anxiolytics <small>(benzodiazepines, sleeping pills)</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Stimulant: Cocaine	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Stimulant: Methamphetamine, other Amphetamines	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Tobacco (nicotine products)	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Over-the-Counter Medications <small>(Cough Syrup, Diet Aids)</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					
Other:  _____	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No					

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**Additional Information:** \_\_\_\_\_

**2. Have you ever experienced an overdose?**  Yes  No

Please describe: \_\_\_\_\_

**3. In the past year, have you found yourself using substances for a longer period of time than you intended?**  Yes  No

Please describe: \_\_\_\_\_

**4. Have you ever experienced being physically ill from withdrawal symptoms when you stop using substances?**  Yes  No

*\* Withdrawal signs & symptoms: e.g. nausea & vomiting; excessive sweating; fever, tremors; seizures; rapid heart rate; blackouts; hallucinations; "DTs" (aka: delirium tremens); anxiety; agitation; depression*

Please describe: \_\_\_\_\_

**5. Are you currently experiencing any withdrawal symptoms as a result of your substance use?**  Yes  No

Please describe specific symptoms (consider immediate referral for medical evaluation): \_\_\_\_\_

**6. Do you have a history of serious seizures or life-threatening symptoms during withdrawal from your substance use?**

Yes  No

Please describe and specify withdrawal substance(s): \_\_\_\_\_

**7. In the past year, have you found yourself needing to use more substances to get the same high?**  Yes  No

Please describe: \_\_\_\_\_

**8. Has your substance use recently changed (increased/decreased/changed route of use)?**  Yes  No

Please describe: \_\_\_\_\_

**9. Have you ever received treatment for your substance use?**  Yes  No

Substance	When	Where	Level of Care	Length of Treatment

Please describe your treatment experience(s) and outcome(s):

\_\_\_\_\_  
 \_\_\_\_\_

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Please rate the client's severity for this dimension by circling one of the following levels of severity:

Dimension 1 (Substance Use, Acute Intoxication, Withdrawal Potential) Severity Rating				
0	1	2	3	4
None	Mild	Moderate	Severe	Very Severe
No signs of withdrawal/intoxication present	Mild/moderate intoxication, interferes with daily functioning. Minimal risk of severe withdrawal. No danger to self/others.	May have severe intoxication but responds to support. Moderate risk of severe withdrawal. No danger to self/others.	Severe intoxication with imminent risk of danger to self/others. Risk of severe manageable withdrawal.	Incapacitated. Severe signs and symptoms. Presents danger, i.e. seizures. Continued substance use poses an imminent threat to life.

**Additional Comments:** \_\_\_\_\_  
 \_\_\_\_\_

## Dimension 2: Biomedical Conditions and Complications

**10. Do you have any of the following physical health conditions or disabilities?**

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Asthma/Respiratory                       | <input type="checkbox"/> Heart Problems              | <input type="checkbox"/> Thyroid Problems  | <input type="checkbox"/> Muscle/Joint Problems |
| <input type="checkbox"/> Seizure/Epilepsy/Neurological            | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Kidney Problems   | <input type="checkbox"/> Vision Problems       |
| <input type="checkbox"/> Sleep Problems                           | <input type="checkbox"/> High Cholesterol            | <input type="checkbox"/> Liver Problems  | <input type="checkbox"/> Hearing Problems      |
| <input type="checkbox"/> Diabetes                                 | <input type="checkbox"/> Blood Disorder              | <input type="checkbox"/> Chronic Pain  | <input type="checkbox"/> Dental Problems       |
| <input type="checkbox"/> Pregnant                                 | <input type="checkbox"/> Stomach/Intestinal Problems | <input type="checkbox"/> Cancer (specify): _____                                       |  |
| <input type="checkbox"/> Sexually Transmitted Infection(s): _____ |  | <input type="checkbox"/> Other Infectious Conditions (Hepatitis, HIV, TB, etc.): _____ |  |
| <input type="checkbox"/> Allergies: _____                         |  | <input type="checkbox"/> Other: (i.e., involved in accident recently, etc.) _____      |  |

**11. Are any of the physical health conditions or disabilities above related to your substance use or current medical health condition(s)?**  Yes  No

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

**12. In the past year, have you continued using substances despite it contributing to health issues?**  Yes  No

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

**13. Do any of these health conditions have an impact on your daily life or functioning?**  Yes  No

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

**14. Have you ever been hospitalized or been evaluated in an emergency room for any physical health problems?**

Yes  No

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Please describe: \_\_\_\_\_

- 15. For assessor to answer: Does the youth client report medical symptoms that would be considered life-threatening or require immediate medical attention?**  Yes  No

*\* If yes, consider immediate referral to emergency room or call 911*

Please describe: \_\_\_\_\_

**Please rate the client's severity for this dimension by circling one of the following levels of severity:**

Dimension 2 (Biomedical Conditions and Complications) Severity Rating				
0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
Fully functional/ able to cope with discomfort or pain.	Mild to moderate symptoms interfering with daily functioning. Adequate ability to cope with physical discomfort.	Some difficulty tolerating physical problems. Acute, nonlife threatening problems present, or serious biomedical problems are neglected.	Serious medical problems neglected during outpatient or intensive outpatient treatment. Severe medical problems present but stable. Poor ability to cope with physical problems.	Incapacitated with severe medical problems.

**Additional Comments:** \_\_\_\_\_

## Dimension 3: Emotional, Behavioral, or Cognitive Conditions or Complications

- 16. Have you ever seen or talked to a counselor or therapist for emotional or behavioral issues ?**  Yes  No

Please describe: \_\_\_\_\_

When	Where	Treatment Setting	Diagnosis	Length of Treatment

- 17. Do you consider any of the following behaviors or symptoms to be problematic for you (e.g., use of substances to cope with emotional, behavioral, or mental health issues as checked below)?**

Mood			
<input type="checkbox"/> Feeling sad or depressed	<input type="checkbox"/> Loss of pleasure or interest in things	<input type="checkbox"/> Feelings of hopelessness or inferiority (e.g., lower than others)	<input type="checkbox"/> Significant changes in appetite or sleep
<input type="checkbox"/> Racing thoughts (e.g., fast, repetitive thought patterns about a particular topic)	<input type="checkbox"/> Rapid or pressured speech (e.g., fast and virtually nonstop talking that is usually cluttered and hard to interrupt)	<input type="checkbox"/> Feeling overly ambitious, grandiose, or narcissistic (e.g., self-absorbed)	

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**Additional Comments:**

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Stress & Anxiety		
<input type="checkbox"/> Feeling anxious/nervous	<input type="checkbox"/> Restlessness <i>(e.g., persistent feeling of being unable to sit still or relax)</i>	<input type="checkbox"/> Having bad dreams/nightmares
<input type="checkbox"/> Compulsive behaviors <i>(e.g., trapped in a pattern of repetitive behaviors that are difficult to overcome)</i>	<input type="checkbox"/> Obsessive thoughts <i>(e.g., excessive worry that is difficult to control)</i>	<input type="checkbox"/> Experiencing flashbacks <i>(e.g., a sudden and disturbing vivid memory of a traumatic event in the past)</i>

**Additional Comments:**

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Psychosis		
<input type="checkbox"/> Paranoia <i>(e.g., fearful feelings and thoughts related to threat, persecution, or conspiracy from others)</i>	<input type="checkbox"/> Hallucinations <i>(e.g., having perceptions of something not present. Could include audio, visual, smell)</i>	<input type="checkbox"/> Delusions <i>(e.g. a false belief that is maintained despite contrary evidence)</i>

**Additional Comments:**

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Attention/Learning		
<input type="checkbox"/> Becoming easily distracted	<input type="checkbox"/> Impulsive <i>(e.g., doing things suddenly and without thinking)</i>	<input type="checkbox"/> Difficulty with paying attention
<input type="checkbox"/> Hyperactivity <i>(e.g., being overactive and having problems with sitting still)</i>	<input type="checkbox"/> Frequently interrupting others	<input type="checkbox"/> Problems with reading/writing/math

**Additional Comments:**

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Behavioral			
<input type="checkbox"/> Hostile or violent acts <i>(e.g., physical fights, forcing sexual activity)</i>	<input type="checkbox"/> Uncontrollable anger issues/ outbursts	<input type="checkbox"/> Bullying or threatening others	<input type="checkbox"/> Destroying property
<input type="checkbox"/> Manipulative or deceitful <i>(e.g., excessive lying)</i>	<input type="checkbox"/> Breaking rules/laws often <i>(e.g., carrying/using dangerous weapons, not going to school/truancy)</i>	<input type="checkbox"/> Stealing/theft	<input type="checkbox"/> Self-harm <i>(e.g., cutting, picking, burning, etc.)</i>

**Additional Comments:**

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Other			
<input type="checkbox"/> Engaging in risky sexual activity <i>(e.g., unprotected intercourse, sexual victimization, sex in exchange for alcohol/drugs, pornography)</i>	<input type="checkbox"/> Severe food restrictions / anorexia	<input type="checkbox"/> Binging or purging	<input type="checkbox"/> Preoccupation with gambling

**Additional Comments:**

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**18. In the past year, do you continue using substances despite it negatively impacting your emotional, behavioral, and/or mental health?**  Yes  No

Please describe: \_\_\_\_\_

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**19. Have you ever experienced any kind abuse (physical, emotional, sexual)?**  Yes  No

Please describe: \_\_\_\_\_

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**20. Have you experienced or witnessed any traumatic or scary event(s) that has stuck with you?**  Yes  No

Please describe: \_\_\_\_\_

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**21. In the past year, have you felt like hurting or killing yourself?**  Yes  No

Please describe: \_\_\_\_\_

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**22. In the past year, have you felt like hurting or killing someone else?**

Yes  No

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

*\* If YES to Q#21 or #22, further assess for current suicide/homicide ideation, intent, plan, target(s), access to lethal means and provide appropriate interventions. Consider Duty to Protect (Tarasoff Law).*

**Please rate the client's severity for this dimension by circling one of the following levels of severity:**

Dimension 3 (Emotional, Behavioral, or Cognitive Conditions and Complications) Severity Rating				
0	1	2	3	4
None	Mild	Moderate	Severe	Very Severe
<b>Good impulse control and coping skills. No dangerousness, good social functioning and self-care, no interference with recovery.</b>	Suspect diagnosis of EBC, requires intervention, but does not interfere with recovery. Some relationship impairment.	Persistent EBC. Symptoms distract from recovery, but no immediate threat to self/others. Does not prevent independent functioning.	Severe EBC, but does not require acute level of care. Impulse to harm self or others, but not dangerous in a 24-hr setting.	Severe EBC. Requires acute level of care. Exhibits severe and acute life-threatening symptoms (posing imminent danger to self/others).

**Additional Comments:** \_\_\_\_\_  
 \_\_\_\_\_

## Dimension 4: Readiness to Change

**23. What do you enjoy about your substance use?**

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

**24. What do you NOT enjoy about your substance use?**

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

**25. In the past year, has your substance use resulted in you failing to complete tasks/activities in important areas of your life?**  Yes  No

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Family relations | <input type="checkbox"/> Work status          | <input type="checkbox"/> Physical Health status     | <input type="checkbox"/> Self-esteem     |
| <input type="checkbox"/> School status    | <input type="checkbox"/> Mental Health status | <input type="checkbox"/> Relationships with others  | <input type="checkbox"/> Sexual Behavior |
| <input type="checkbox"/> Friendships      | <input type="checkbox"/> Money                | <input type="checkbox"/> Extracurricular Activities | <input type="checkbox"/> Social Life     |
| <input type="checkbox"/> Legal status     | <input type="checkbox"/> Hygiene              | <input type="checkbox"/> Other: _____               |  |

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

**26. In the past year, did you continue to use substances despite it affecting the areas listed above?**

Yes  No

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

**27. In the past year, have you used substances in physically hazardous situations (e.g., under the influence while driving a car, unprotected sexual activity, etc.)?**

Yes  No

Please describe: \_\_\_\_\_  
 \_\_\_\_\_

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**28. Using a scale from 0-10 (with 0 meaning “not at all ready” and 10 “very ready”), how ready are you to stop or cut back your use of:** ( Not applicable)

<b>Alcohol</b>	Not at all ready	0	1	2	3	4	5	6	7	8	9	10	Very Ready
<b>Marijuana</b>	Not at all ready	0	1	2	3	4	5	6	7	8	9	10	Very Ready
<b>Other drugs</b>	Not at all ready	0	1	2	3	4	5	6	7	8	9	10	Very Ready

**Please rate the client’s severity for this dimension by circling one of the following levels of severity:**

Dimension 4 (Readiness to Change) Severity Rating				
0 None	1 Mild	2 Moderate	3 Severe	4 Very Severe
Willing to engage in treatment.	Willing to enter treatment, but ambivalent to the need to change.	Reluctant to agree to treatment. Low commitment to change substance use. Passive engagement in treatment.	Unaware of need to change. Unwilling or partially able to follow through with recommendations for treatment.	Not willing to change. Unwilling/unable to follow through with treatment recommendations.

**Additional Comments:**

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## Dimension 5: Relapse, Continued Use, or Continued Problem Potential

**29. How would you describe your desire/urge to use substances on a scale from 0 to 10 (with 0 being none and 10 being high)?**

None	0	1	2	3	4	5	6	7	8	9	10	High
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Please describe: \_\_\_\_\_

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**30. In the past year, have you found yourself spending a lot of time getting, using, or recovering from the effects of your substance use?**  Yes  No

Please describe: \_\_\_\_\_

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**31. In the past year, have you found it hard to cut down or stop your substance use, despite wanting to do so?**  Yes  No

Please describe: \_\_\_\_\_

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**32. Do you feel that you will continue to use substances without help or additional support?**  Yes  No

Please describe: \_\_\_\_\_

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**33. Are there important stressors or triggers in your life that contribute to your substance use?**  Yes  No

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Academic / School Issues                            | <input type="checkbox"/> Peer Pressure         | <input type="checkbox"/> Work Pressures      |
| <input type="checkbox"/> Family Issues                                       | <input type="checkbox"/> Relationship Problems | <input type="checkbox"/> Unemployment        |
| <input type="checkbox"/> Strong Cravings                                     | <input type="checkbox"/> Sexual victimization  | <input type="checkbox"/> Living Environment  |
| <input type="checkbox"/> Physical Health Issues                              | <input type="checkbox"/> Bullying              | <input type="checkbox"/> Financial Stressors |
| <input type="checkbox"/> Chronic Pain  | <input type="checkbox"/> Mental Health Issues  | <input type="checkbox"/> Gang involvement    |
| <input type="checkbox"/> Weight Issues                                       | <input type="checkbox"/> Sexual Orientation    | <input type="checkbox"/> Immigration Issues  |
| <input type="checkbox"/> Legal issues (DCFS, probation, court mandate, etc.) | <input type="checkbox"/> Gender Identity       | <input type="checkbox"/> Other               |

**34. Have you ever attempted to either stop or cut down your substance use?**  Yes  No

Please describe: \_\_\_\_\_  
\_\_\_\_\_

**35. What is the longest period of time that you have gone without using substances?**

Please describe: \_\_\_\_\_  
\_\_\_\_\_

**36. What do you typically do to deal with your stressors or triggers?**

Please describe: \_\_\_\_\_  
\_\_\_\_\_

**37. What would help support you change or stop your substance use?**

Please describe: \_\_\_\_\_  
\_\_\_\_\_

**Please rate the client's severity for this dimension by circling one of the following levels of severity:**

Dimension 5 (Relapse, Continued Use, or Continued Problem Potential) Severity Rating				
0	1	2	3	4
<i>None</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>	<i>Very Severe</i>
<b>Low/no potential for relapse. Good ability to cope.</b>	Minimal relapse potential. Some risk, but fair coping and relapse prevention skills.	Impaired recognition of risk for relapse. Able to self-manage with prompting.	Little recognition of risk for relapse, poor skills to cope with relapse.	No coping skills for relapse/ addiction problems. Substance use/behavior, places self/other in imminent danger.

**Additional Comments:** \_\_\_\_\_  
\_\_\_\_\_

## Dimension 6: Recovery/Living Environment

**38. What is your current living situation (e.g. homeless, living with family/friends/alone)?**

Please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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39. Are you currently in an environment where others (e.g., family, friends, peers, significant others, roommates, neighborhood, school) use substances?  Yes  No

Please describe: \_\_\_\_\_  
\_\_\_\_\_

## Support/Safety

40. Do you have reliable transportation?  Yes  No

Please describe: \_\_\_\_\_  
\_\_\_\_\_

41. Do you have relationships (e.g., family, peers/friends, mentor, coach, teacher, etc.) that are supportive of you stopping or reducing your substance use?  Yes  No

Please describe: \_\_\_\_\_  
\_\_\_\_\_

42. Are you currently involved in any relationships or situations (e.g., being bullied, violence in your home and/or neighborhood, abuse (physical, mental, emotional) that pose a threat to your safety and could impact you stopping or reducing your substance use?  Yes  No

Please describe: \_\_\_\_\_  
\_\_\_\_\_

## Education / Employment

43. Are you currently enrolled in school?  Yes  No

Please describe: \_\_\_\_\_  
\_\_\_\_\_

44. Are you currently employed?  Yes  No

Please describe: \_\_\_\_\_  
\_\_\_\_\_

45. In the past year, have you experienced any significant problems at home, school or work?  Yes  No

Please describe: \_\_\_\_\_

Home \_\_\_\_\_

School \_\_\_\_\_

Work \_\_\_\_\_

## Social/Recreational

46. What type of social/recreational activities do you like to do?

Please describe: \_\_\_\_\_  
\_\_\_\_\_

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Please rate the client's severity for this dimension by circling one of the following levels of severity:

Dimension 6 Recovery/Living Environment Severity Rating				
0	1	2	3	4
None	Mild	Moderate	Severe	Very Severe
Able to cope in environment/supportive.	Passive/disinterested social support, but still able to cope.	Unsupportive environment, but able to cope with clinical structure most of the time.	Unsupportive environment, difficulty coping even with clinical structure.	Environment toxic/hostile to recovery. Unable to cope and the environment may pose a threat to safety.

**Additional Comments:**

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Based on the ASAM Criteria [3<sup>rd</sup> Edition] Multidimensional Assessment

## Summary of Multi-Dimensional Assessment

Dimension	Severity Rating (based on ratings above)				Rationale for Severity Rating
<b>Dimension 1</b> Substance Use, Acute Intoxication, Withdrawal Potential	<input type="checkbox"/> 0 None	<input type="checkbox"/> 1 Mild	<input type="checkbox"/> 2 Moderate	<input type="checkbox"/> 3-4 Severe	
<b>Dimension 2</b> Biomedical Condition and Complications	<input type="checkbox"/> 0 None	<input type="checkbox"/> 1 Mild	<input type="checkbox"/> 2 Moderate	<input type="checkbox"/> 3-4 Severe	
<b>Dimension 3</b> Emotional, Behavioral, or Cognitive Condition and Complications	<input type="checkbox"/> 0 None	<input type="checkbox"/> 1 Mild	<input type="checkbox"/> 2 Moderate	<input type="checkbox"/> 3-4 Severe	
<b>Dimension 4</b> Readiness to Change	<input type="checkbox"/> 0 None	<input type="checkbox"/> 1 Mild	<input type="checkbox"/> 2 Moderate	<input type="checkbox"/> 3-4 Severe	
<b>Dimension 5</b> Relapse, Continued Use, or Continued Problem Potential	<input type="checkbox"/> 0 None	<input type="checkbox"/> 1 Mild	<input type="checkbox"/> 2 Moderate	<input type="checkbox"/> 3-4 Severe	
<b>Dimension 6</b> Recovery/Living Environment	<input type="checkbox"/> 0 None	<input type="checkbox"/> 1 Mild	<input type="checkbox"/> 2 Moderate	<input type="checkbox"/> 3-4 Severe	

## Determining Youth Medical Necessity

In order to deliver specialty substance use disorder (SUD) services to Youth (Age 12-17) and Young Adults (age 18-20), a provider must determine if the youth meets medical necessity. To meet medical necessity, at least one of the two medical necessity criteria outlined below must be met:

1. Have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) 5 for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance- Related Disorders, and meet the ASAM Criteria for necessary services

**OR**

2. Be assessed to be at-risk for developing a substance use disorder (SUD)

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**Client Name:** \_\_\_\_\_  
**Medi-Cal or My Health LA ID:** \_\_\_\_\_  
**Treatment Provider:** \_\_\_\_\_

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## DSM-5 SUD Diagnostic Criteria

Determining if youth meet SUD diagnostic criteria using the DSM-5:

The table below includes the DSM-5 criteria for Substance-Related and Addictive Disorders. These areas are covered in the ASAM assessment questions that are highlighted in grey (throughout the sections above).

- For each substance, check off any criteria that have been apparent in the past 12 months.
- After the completion of the table, put the total number of checked boxes ("yes" responses) in the Criteria Met section.

	Substance Use Disorder Criteria (DSM-5)	Name of Substance(s)		
		#1: <hr style="width: 100%;"/>	#2: <hr style="width: 100%;"/>	#3: <hr style="width: 100%;"/>
1	Substance often taken in larger amounts or over a longer period than was intended.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	There is a persistent desire or unsuccessful efforts to cut down or control substance use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	Craving, or a strong desire or urge to use the substance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	Important social, occupational, or recreational activities are given up or reduced because of substance use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	Recurrent substance use in situations in which it is physically hazardous.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	Continued substance use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	Tolerance, as defined by either of the following: - A need for markedly increased amounts of the substance to achieve intoxication or desired effect. - A markedly diminished effect with continued use of the same amount of the substance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	Withdrawal, as manifested by either of the following: - The characteristic withdrawal syndrome for the substance. - Substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Total Number of Criteria Met</b>				

**List of Substance Use Disorder(s) and Severity Level that Meet DSM-5 Criteria:**

	<input type="checkbox"/> Mild (2-3)	<input type="checkbox"/> Moderate (4-5)	<input type="checkbox"/> Severe (6+)
	<input type="checkbox"/> Mild (2-3)	<input type="checkbox"/> Moderate (4-5)	<input type="checkbox"/> Severe (6+)
	<input type="checkbox"/> Mild (2-3)	<input type="checkbox"/> Moderate (4-5)	<input type="checkbox"/> Severe (6+)

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**Client Name:** \_\_\_\_\_

**Medi-Cal or My Health LA ID:** \_\_\_\_\_

**Treatment Provider:** \_\_\_\_\_

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**“At-Risk”:** If clients do not meet the DSM-5 criteria for a substance use disorder, they can also meet medical necessity by meeting the “at-risk” criteria for *Youth (age 12-17) and Young Adults (age 18-20)*, as specified in the **“At-Risk Determination Tool”** below.

## At-Risk Determination Tool

Youth or Young adults under the age of 21 may be determined to be “at-risk” if they meet the following criteria:

1. If the substance use does NOT meet the minimum criteria for a substance use disorder from the current Diagnostic and Statistical Manual (DSM) of Mental Disorders for Substance-Related Disorders (with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders);

**AND**

2. Determined to be at-risk of developing a substance use disorder based on reports of experimental or early-phase substance use, associated biopsychosocial risk factors, and information gathered from the full ASAM assessment and At-Risk Determination Tool (below)

**Determining if Youth and Young Adult meet “at-risk” criteria for medical necessity:**

Using information from the full ASAM assessment, including the DSM-5 criteria and professional judgement, complete the following table (where applicable) to identify and describe risk factors and their impact on the client’s SUD risk in each of the ASAM Dimensions.

ASAM Dimension	Example of At-Risk Indicators (check all that apply)	Describe Impact on Client’s SUD Risk:
<b>Dimension 1:</b> <i>Acute Intoxication and / or Withdrawal Potential</i>	<input type="checkbox"/> Early initiation and misuse of substances: Initiation and use under 12 years of age <input type="checkbox"/> Consumption: Any use of substances by youth in the past year <input type="checkbox"/> Poly-substance use: Use of more than one substance, including tobacco <input type="checkbox"/> Route of use: Injecting substances <input type="checkbox"/> History of prior overdose <input type="checkbox"/> Previous treatment for alcohol or drug use <input type="checkbox"/> Other: _____ _____	
<b>Dimension 2:</b> <i>Biomedical Conditions/ Complications</i>	<input type="checkbox"/> Chronic pain <input type="checkbox"/> Other: _____ _____	
<b>Dimension 3:</b> <i>Emotional, Cognitive, Behavioral Health Conditions/ Complications</i>	<input type="checkbox"/> Mental health issues <input type="checkbox"/> Substance use to deal with mental health issues, weight issues, victimization, gang, bullying, etc. <input type="checkbox"/> Other: _____ _____	

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ASAM Dimension	Example of At-Risk Indicators (check all that apply)	Describe Impact on Client's SUD Risk:
<b><u>Dimension 4:</u></b> <i>Readiness to Change</i>	<input type="checkbox"/> Substance use in hazardous situations (e.g., driving under the influence; use and risky sexual behaviors) <input type="checkbox"/> Other: _____ _____	
<b><u>Dimension 5:</u></b> <i>Relapse / Continued Use or Problem Potential</i>	<input type="checkbox"/> Stressors/triggers in life that contribute to substance use (e.g., pressure/issues from school, peers, family, legal) <input type="checkbox"/> Other: _____ _____	
<b><u>Dimension 6:</u></b> <i>Recovery Environment (Living Situation)</i>	<input type="checkbox"/> Friends and/or family who use substances <input type="checkbox"/> Lack of social support <input type="checkbox"/> Threatening relationships/situations that impact substance use <input type="checkbox"/> Other: _____ _____	

**At-Risk Determination Narrative:**

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**Youth or Young Adult is determined to be "at-risk" for developing a substance use disorder**  Yes  No

Upon an "at-risk" determination, youth and young adults are eligible for short-term intervention services (e.g., counseling and case management) for their substance use through the EPSDT Medi-Cal benefit. These services are low-intensity, limited to 16 units of service (in 15 minute increments; totaling 4 hours), and must be provided in outpatient SUD settings.

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# LOS ANGELES COUNTY ASSESSMENT TOOL- YOUTH (Paper Version)

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## ASAM LEVEL OF CARE DETERMINATION TOOL

Instructions: For each dimension, indicate the least intensive level of care that is appropriate based on the client’s severity/functioning and service needs.

ASAM Criteria Level of Care	ASAM Level	Dimension 1 Substance Use, Acute Intoxication and/or Withdrawal Potential				Dimension 2 Biomedical Condition and Complications				Dimension 3 Emotional, Behavioral, or Cognitive Condition and Complications				Dimension 4 Readiness to Change				Dimension 5 Relapse, Continued Use, or Continued Problem Potential				Dimension 6 Recovery/Living Environment			
		None (0)	Mild (1)	Mod (2)	Sev* (3-4)	None (0)	Mild (1)	Mod (2)	Sev (3-4)	None (0)	Mild (1)	Mod (2)	Sev (3-4)	None (0)	Mild (1)	Mod (2)	Sev (3-4)	None (0)	Mild (1)	Mod (2)	Sev (3-4)	None (0)	Mild (1)	Mod (2)	Sev (3-4)
Early Intervention	0.5																								
Outpatient Services	1																								
Intensive Outpatient Services	2.1																								
Partial Hospitalization Services	2.5																								
Clinically Managed Low-Intensity Residential Services	3.1																								
Clinically Managed Population-Specific High-Intensity Residential Services	3.3																								
Clinically Managed High-Intensity Residential Services	3.5																								
Medically Monitored Intensive Inpatient Services	3.7																								
Medically Managed Intensive Inpatient Services	4																								

Consider referral to mental health facility

**\* Note: Withdrawal Management and Medication-Assisted Treatment (MAT) services are available for youth under 18 years of age on a case-by-case basis with SAPC approval. Please contact SAPC for further details.**

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Client Name: \_\_\_\_\_  
 Medi-Cal or My Health LA ID: \_\_\_\_\_  
 Treatment Provider: \_\_\_\_\_

# LOS ANGELES COUNTY ASAM ASSESSMENT-YOUTH (Paper Version)

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## Placement Summary

**Level of Care:** Enter the ASAM Level of Care number (e.g., 1.0, 2.1, 3.1,3.5) that offers the most appropriate treatment setting given the client's current severity and functioning: \_\_\_\_\_

**Note:** Youth and Young Adults determined to be "at-risk" for a Substance Use Disorder are eligible for short-term intervention services (e.g., counseling and case management) for their substance use through the EPSDT Medi-Cal benefit. These services are low-intensity, limited to 16 units of service (in 15 minute increments; totaling 4 hours), and must be provided in outpatient SUD settings.

**Level of Care Provided:** \_\_\_\_\_

If the most appropriate Level of Care is not utilized, then enter the next appropriate Level of Care and check off the reason(s) for this discrepancy with brief explanation below:

**Reason for Discrepancy:**

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Not Applicable                    | <input type="checkbox"/> Service Not Available | <input type="checkbox"/> Provider Judgment | <input type="checkbox"/> Client Preference |
| <input type="checkbox"/> Transportation                    | <input type="checkbox"/> Accessibility         | <input type="checkbox"/> Financial         | <input type="checkbox"/> Preferred to Wait |
| <input type="checkbox"/> Language/ Cultural Considerations | <input type="checkbox"/> Environment           | <input type="checkbox"/> Mental Health     | <input type="checkbox"/> Physical Health   |
| <input type="checkbox"/> Other: _____                      |  |  |  |

Briefly Explain Discrepancy: \_\_\_\_\_

Designated Treatment Location and Provider Name: \_\_\_\_\_

Counselor Name (if applicable)	Signature	Date
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Licensed eligible LPHA Name (if applicable)	Signature	Date
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*Licensed LPHA Name	Signature	LPHA License #	Date
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Licensed-eligible LPHA's are psychological assistants, associate social workers (ASWs), marriage and therapy family interns (MFTI/IMFT), and professional clinical counselor intern (PCCI).

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	Medi-Cal or My Health LA ID: _____
	Treatment Provider: _____

# LOS ANGELES COUNTY ASAM ASSESSMENT-YOUTH (Paper Version)

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\*A Licensed LPHA is required to sign the ASAM assessment. Licensed LPHA (Licensed Practitioner of the Healing Arts) includes: Physician, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT).

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Client Name: \_\_\_\_\_

Medi-Cal or My Health LA ID: \_\_\_\_\_

Treatment Provider: \_\_\_\_\_