

CHILDREN'S ADMINISTRATION GAIN-SS

Version (GVER): GSS-annual 2.0.1

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CLIENT NAME (FIRST, MIDDLE, LAST)		1. DATE	2. <input type="checkbox"/> Adult <input type="checkbox"/> Youth	3. <input type="checkbox"/> Client Refused to Answer Questions <input type="checkbox"/> Client Unable to Answer Questions	
CLIENT TELEPHONE NUMBER	CLIENT DATE OF BIRTH	4. CAMIS PERSON ID		RACE/ETHNICITY	
CLIENT ADDRESS			CITY	STATE	ZIP CODE
SOCIAL WORKER'S NAME				SOCIAL WORKER TELEPHONE NUMBER	
5. Client referred for assessment <input type="checkbox"/> Mental Health <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Co-occurring <input type="checkbox"/> Client not referred		6. Client currently receiving service <input type="checkbox"/> Mental Health <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Co-occurring		7. <input type="checkbox"/> Child Protective Services (CPS) <input type="checkbox"/> Family Voluntary Services <input type="checkbox"/> Family Reconciliation Services (FRS) <input type="checkbox"/> Child and Family Welfare Services <input type="checkbox"/> Child Health & Education Track (CHET)	

Global Appraisal of Individual Needs-Short Screener (GAIN-SS)

*The following questions are about common psychological, behavioral or personal problems. These problems are considered **SIGNIFICANT** when you have them for **two or more weeks**, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. Please answer the questions "YES" or "NO".*

Mental Health Internalizing Behaviors (IDScr 1): During the past 12 months, have you had significant problems

a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. with sleep trouble, such as bad dreams, sleeping restlessly or falling sleep during the day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. with feeling very anxious, nervous, tense, scared, panicked or like something bad was going to happen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. when something reminded you of the past, you became very distressed and upset?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. with thinking about ending your life or committing suicide?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If TWO or more "YES" answers, refer to Mental Health, except if positive on (e) for suicide, refer to CRISIS LINE or DMHP (Designated Mental Health Professional).

Mental Health Externalizing Behaviors (EDScr 2): During the past 12 months, did you do the following things two or more times?

a. Lie or con to get things you wanted or to avoid having to do something?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Have a hard time paying attention at school, work or home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Have a hard time listening to instructions at school, work or home?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Been a bully or threatened other people?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Start fights with other people?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If TWO or more "YES" answers, refer to Mental Health

Substance Abuse Screen (SDScr 3): During the past 12 months, did.....

a. you use alcohol or drugs weekly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. you spend a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. you keep using alcohol or drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. your use of alcohol or drugs cause you to give up, reduce or have problems at important activities at work, school, home or social events?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. you have withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or use any alcohol or drugs to stop being sick or void withdrawal problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

If TWO or more "YES" answers in Substance Abuse or Co-occurring, (Substance Abuse AND Mental Health), refer to CDP or Substance Abuse Treatment Provider

I understand that a copy of this form may become part of a referral for services.

SIGNATURE	DATE
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