DELAWARE DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

TRANSITION AGE YOUTH BRIEF SCREEN

DATE OF APPLICATION**:**

CLIENT NAME:	DOB:	RACE:	MCI#:
CLIENT CONTACT NUMBER:	CLIENT ADDRESS:	CLIENT EMAIL (IF APPLICABLE):	REFERRING AGENCY:

Thank you for your interest in the Transition Age Youth (TAY) program. Please carefully read the following:

Check yes to all that apply. Do not leave any questions unanswered. If incomplete, TAY staff will return this form indicating that it is incomplete. Returned forms will have 30 days to be completed and resubmitted to the TAY program or the case will be considered closed.

1. Has the client been diagnosed with a severe and persistent mental illness (SPMI)?
   ☐ Yes ☐ No

2. Does the client have a history of substance use treatment?
   ☐ Yes ☐ No

3. Is DFS the primary custodian or legal guardian?
   ☐ Yes ☐ No

4. Has the client been hospitalized in the past 12 months for psychiatric care?
   ☐ Yes ☐ No

5. Identify services the client is currently involved with:
   ☐YRS ☐PBH ☐DFS ☐DDDS ☐DVR

6. Does the client have a history of criminal behavior?
   ☐ Yes ☐ No

7. Does the client have a diagnosed intellectual disability?
   ☐ Yes ☐ No

8. Does the client have adequate family or external supports?
   ☐ Yes ☐ No

9. Does the client have safe housing?
   ☐ Yes ☐ No

10. Is the client's legal guardian aware of this referral?
    ☐ Yes ☐ No ☐ N/A

11. What specific service(s) is the client currently in need of or seeking assistance with obtaining?

Please provide additional notes in the space below if applicable.

****Please note, the Brief Screen can be reviewed without a psychiatric evaluation OR psych notes. However, to proceed with referrals to several programs, a signed release of information and a current psychiatric evaluation (within a calendar year) OR the client's last three (most recent) psych notes are needed to complete the application for submission. If they are not provided, as needed per program submission, it will impact the ability to make the appropriate referrals.**

Client Signature _____ Date _____

Parent/Legal Guardian Signature _____ Date _____
(If under 18)

Staff Signature _____ Date_____

Staff Supervisor Name _____

Complete the brief screen in its entirety and send to DSAMH_TAY@delaware.gov