NH Wraparound (FAST Forward) Intake and Needs Based Eligibility Form

Case information

Referral Source: _____

Referral Date: _____

Interim Supports List (ISL) #: _____

Youth Medicaid #: _____

Case ID#: _____

Family information

1. Youth first name: _____ Middle Initial: _____ Last name: _____

Youth preferred name: _____

Youth preferred pronoun (he/she/they/other): _____

2. Youth preferred spoken language: _____ Interpreter needed? _____

Youth preferred written language: _____ Translator needed? _____

3. Youth date of birth: _____ Age: _____

4. Youth street address: _____

City: _____

State: _____

Zip code: _____

5. Preferred method of contact: _____

Best contact number: _____

Ok to receive texts at this number? _____

Email address: _____

6. Name of legal guardian or responsible party: _____

Relationship to youth: ☐ birth parent ☐ step parent ☐ adoptive parent ☐ foster parent ☐ grandparent ☐ sibling

☐ other relative ☐ non-relative not previously listed ☐ prefer not to answer

Siblings (name and age):

Other relationships in home:

Preferred spoken language: _____ Interpreter needed? _____

Preferred written language: _____ Translator needed? _____

Language spoken at home: _____

7. Weapons in the home? _____ If so, how secured? _____

8. Primary reasons for referral
What kinds of difficulties is [youth's name] experiencing? **(check all that apply)**

- ☐ Conduct/delinquency
- ☐ Intellectual disabilities
- ☐ Hyperactive/attention deficit
- ☐ School/educational performance
- ☐ Depression
- ☐ Anxiety
- ☐ Adjustment-related issues
- ☐ Suicide-related thoughts/actions
- ☐ Self-injury
- ☐ Persistent noncompliance
- ☐ Specific developmental disabilities
- ☐ Separation problems
- ☐ Psychotic behaviors
- ☐ Substance misuse, abuse, drug dependency
- ☐ Learning disabilities
- ☐ Eating disorders
- ☐ Sleeping problems
- ☐ Current home unable to meet child's needs
- ☐ Maltreatment
- ☐ Behavioral concerns
- ☐ Excessive crying/tantrums
- ☐ Feeding problems
- ☐ Excluded from preschool or childcare due to behavioral or developmental problems
- ☐ Attachment problems

Primary psychiatric diagnosis, if applicable: _____

Secondary psychiatric diagnosis, if applicable:

Strengths used to help with challenges:

9. Living situation at time of referral (check all that apply)

- ☐ Home
- ☐ Youth detention
- ☐ Guardian (relative)
- ☐ Residential
- ☐ Foster Care (non-relative)
- ☐ Guardian (non-relative)
- ☐ Psychiatric hospital
- ☐ Other (specify below)

_____

10. Out of home placement history (including but not limited to foster care, relatives, group home, residential, hospital, detention or emergency shelter; please use comments for additional information)

Name/Type of Placement	Reason for Placement	Date(s)

11. Hospital visits

In the past 12 months, how many times has the youth been hospitalized for psychiatric reasons? _____

In the past 12 months, how many youth emergency room visits for psychiatric reasons? _____

12. Was child/youth ever adopted? (Y/N) _____

13. Systems through which the child is presently receiving services or supports
a. Juvenile Justice

Juvenile Justice Involvement? (Y/N) _____ Adjudicated or Non-adjudicated? _____

Probation officer's name: _____ Phone: _____

Voluntary CHINS or Court-ordered CHINS/delinquency? _____

b. Child Protection

Child Protection Involvement (Y/N): _____ Current child abuse/neglect assessment: _____

Out of home placement (select one): Foster care ☐ Relative ☐ Residential ☐

In home services (Y/N): _____ If yes, please specify: _____

DCYF Worker: _____ Phone: _____

c. Educational involvement and educational services

School attended: _____ School District: _____

School Region (Region A, Region B, or Region C): _____

School services (specify IEP or 504 plan): _____

Primary and secondary IEP coding, if applicable: _____

School contract person & role: _____

d. Medical services/needs

Ongoing medical conditions (specify yes or no): _____

If yes, please describe: _____

Prescribed medications for medical conditions (indicate yes or no): _____

If yes, please describe: _____

e. Mental health services

Are you receiving: ☐ private, home-based mental health services ☑ community mental health center-based services

☐ no mental health services

Therapist: _____ Therapist's agency: _____

Psychiatrist: _____ Psychiatrist's agency: _____

Case manager & contact info: _____

Prescribed psychotropic medications (please list): _____

f. Developmental disability services

Are you receiving developmental disability services? (If yes, indicate which) _____

Provider: _____ Provider's agency: _____

Provider contact info: _____

14. During the past 6 months was the youth the recipient of: (check all that apply)

Medicaid	☐	Supplemental Security Income (SSI)	☐	Other:	☐
Food Stamps	☐	Women, infant, and children (WIC)	☐		
Private insurance	☐	Temporary assistance to needy families (TANF)	☐		

15. Prior services/supports that the child/family has utilized in the past *What kinds of services have you or your family received?* (check all that apply)

Individual therapy	☐	Trauma focused CBT	☐	Parenting classes	☐
Family therapy	☐	Dialectical Behavior Therapy	☐	School to careers	☐
Youth case management	☐	Multi-systemic therapy	☐	Crisis intervention program	☐
Group therapy	☐	Psychiatric services	☐	Batterer's intervention group	☐
Family case management	☐	On-call crisis services	☐	Domestic violence support	☐
School-based behavioral supports	☐	Inpatient hospitalization	☐	Substance misuse treatment	☐
Home base services	☐	Partial hospitalization	☐	HeadStart	☐
Respite, in or out-of-home	☐	Intensive outpatient	☐	Outreach	☐

16. Services & Supports that PARENT/GUARDIAN and/or SIBLINGS are presently receiving:

Recipient	Services and supports

17. Ethnicity

Is the youth of Hispanic, Latino/a, or Spanish origin? Yes ☐ No ☐

If yes, which group describes his/her Hispanic, Latino/a, or Spanish origin? (select all that apply)

Central American	☐	Mexican or Chicano	☐	Other Hispanic	☐
Cuban	☐	Puerto Rican	☐	Declined (don't ask again)	☐
Dominican	☐	South American	☐	Unavailable/unknown	☐

18. Race: Which Best Describes the Child/Youth? Are They…(select all that apply)

African American	☐	Guamanian/Chamorro	☐	White	☐
Alaska Native	☐	Japanese	☐	Other Asian	☐
American Indian	☐	Korean	☐	Other Pacific Islander	☐
Asian Indian	☐	Native Hawaiian	☐	Declined (Don't ask again)	☐
Chinese	☐	Samoan	☐	Unavailable/unknown	☐
Filipino	☐	Vietnamese	☐		

19. Gender Identity

What sex was the youth assigned on their original birth certificate? _____

What is the youth's Current Gender Identity (Select all that apply)

Female	☐	Trans female/woman	☐	Gender queer/Non-conforming	☐
Male	☐	Trans male/man	☐	Different identity (specify):	_____

20. Sexual Orientation

Do you think of yourself as (select from options below):

Bisexual ☐ Lesbian or gay ☐ Straight ☐ Something else ☐ Don't know ☐

21. Desired outcome from participation in this program?

22. Additional notes or comments

To be completed by the Intake/Eligibility Coordinator:

To be eligible for wraparound, the youth must meet all of the following criteria:	Yes/No (check one)	
Between the ages of 5 - 21	Yes	No
Designation of serious emotional disturbance (SED) or at-risk of SED	Yes	No
Multi-system involved (e.g., mental health, educational, medical, developmental disability, JJ, DCYF)	Yes	No
Non-responsive to existing school or community-based services	Yes	No
Medicaid eligible	Yes	No