



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

\*Please complete this form to the best of your abilities\*

Referral information			
Client ID (If Applicable):	Medicaid ID:		
Referral Source:	Referral Date:		
Referent Name:	Referent Contact:		
Referral type: DCYF $\Box$ Mental Health $\Box$ Education	$\Box$ Healthcare $\Box$ Self $\Box$ Other:		
Has the family consented to the referral? Yes $\Box$ I	No 🗆		
Youth Information			
Legal first name: Mid	dle Initial: Legal Last name:		
Youth preferred name:			
Personal pronoun (he/she/they/other):			
Youth date of birth:	Age:		
Preferred written language:	Preferred spoken language:		
Youth street address:			
City:			
State:			
ZIP Code:			
Interpreter needed? Yes $\Box$ No $\Box$			
Other accommodations? Yes  No  If yes, explain	1:		
Youth living situation			
At time of referral (check all that apply)			
Home 🗌 Residential 🗌	Psychiatric hospital		
Youth detention $\Box$ Foster care (non-relative) $\Box$	Other (specify below)		
Weapons in the home(s)? Yes 🗌 No 🗌 If yes, how secured?			
Caregiver 1 information			
Legal first name:	Legal last name:		
Primary contact? Yes 🗌 No 🗌	Legal guardian or Yes 🗌 No 🗌 responsible party?		
Relationship toImage: Birth parentImage: Step parentImage: Adoptive parentImage: Foster parentImage: GrandparentImage: Siblingyouth:Image: Other relativeImage: Non-relative not previously listedImage: Prefer not to answer			
Percent time living with this 0-24%  25-49%  50-74%  75-100%			
Best contact number:			
OK to receive texts at this number? Yes $\Box$ No $\Box$			
Email address:			
Preferred written language?	Preferred spoken language:		

Interpreter needed? Yes 🗌 No 🗌			
Other accommodations? Yes 🗌 No 🗌 If yes, explain:			
Caregiver 2 Information			
Legal first name: Legal last name:			
Primary contact? Yes 🗌 No 🗌 🛛 Legal guardian or responsible party? Yes 🔲 No 🗌			
Relationship to          Birth parent           Step parent           Adoptive parent           Foster parent           Grandparent          youth:          Other relative           Non-relative not previously listed           Prefer not to answer			
Percent time living with this caregiver: 0-24% $\Box$ 25-49% $\Box$ 50-74% $\Box$ 75-100% $\Box$			
Best contact number:			
OK to receive texts at this number? Yes $\Box$ No $\Box$			
Email address:			
Preferred written language? Preferred spoken language:			
Interpreter needed? Yes 🗌 No 🗌			
Other accommodations needed? Yes 🗆 No 🗆 If yes, explain:			
Please attach supporting guardianship documentation or up to date parenting agreements, if applicable			
Family and other relationships			
First name, last name, age of all siblings:			
First name, last name, type of relationship of all other people living in the youth's home(s): Has the youth or any member of their family ever served in the military? Yes D No D			
Youth sexual orientation, gender identity, sex at birth			
Does the youth think of themselves as (check one): Bisexual 🗆 Gay or lesbian 🗆 Straight or heterosexual 🗆			
Something else (e.g., queer, pansexual, asexual) 🗌 please specify:			
Don't know  Choose not to disclose			
Youth's current Gender Identity (select all that apply)			
Girl/Woman 🗌 Transgender Girl/Woman 🗌 Something else (e.g., non-binary, genderqueer, gender fluid) 🗌 Boy/Man 🗌 Transgender Boy/Man 🗌 Choose not to disclose 🗌			
Sex youth was assigned at birth (check one):			
Female 🗆 Male 🗆 Intersex 🗆 Choose not to disclose 🗆			

Youth ethnicity					
Is the youth of Hispanic, Latino/a, or Spanish origin? Yes $\Box$ No $\Box$					
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	
Youth race					
Which of the following	ng race(s) best	describe the youth? (se	lect all that appl	y)	
African American		Guamanian/Chamor	ro 🗆	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			

## Youth and family strengths

What are the youth and family best at? What does the youth/family like to do? What helps them when times are tough? Who can they count on for support?

#### Youth challenges and concerns

What kinds of difficulties is the youth experiencing? (check all that apply)

- □ Adjustment-related issues
- Disordered Eating (Diagnosed eating disorder)
- Externalizing behaviors (fighting, acting out, delinquency)
- Family concerns
- □ Gender identity/sexual orientation
- □ Grief/loss
- □ History of Trauma/Victimization/Abuse/Neglect
- Intellectual/developmental disabilities
- Other (please explain):

#### **Current primary psychiatric Dx:**

#### **Historical psychiatric Dxs:**

- □ Internalizing behaviors (sad, anxious, withdrawn)
- Problems with attention and concentration
- □ School/educational concerns
- □ Sleeping problems (Difficulty falling asleep/waking up)
- □ Social/friendship concerns
- Substance misuse, abuse, drug dependency
- □ Suicide, self-injury, self-harm
- Symptoms of psychosis (hallucinations, delusions, etc.)

Dx Code(s):

### ED and hospital visits

Name/Type

How many times has the youth gone to the emergency room for psychiatric reasons in the past *12 months*? How many times has the youth been hospitalized for psychiatric reasons in the past *12 months*? How many times has the youth been hospitalized for psychiatric reasons in their *lifetime*? When was the youth most recently hospitalized for psychiatric reasons?

Reason

Residential treatment (including but not limited to foster care, relatives, group home, residential, hospital, detention or emergency shelter; please use comments for additional information)

Mental he	alth services		
Is the youth	n currently receiving mental health se	rvices? Yes 🗌 No 🗆	
Where?	Home 🗌 🛛 Clinic/office 🗆		
From whom	n? Community mental health cente	r 🗆 Private clinic/therapist 🛙	
Name of MI	H agency		
What type(	s)? Substance misuse treatment □	Family therapy 🗆 Day treatment 🗆	Group therapy $\Box$ Case management $\Box$
Therapist:		Phone:	
Psychiatrist	:	Phone:	
Case manag	ger:	Phone:	
DCYF Serv	ices		
Is the child	or youth <i>currently</i> involved with DCYF	? Yes 🗆 No 🗆	
Type?	Juvenile Justice $\Box$	Child Protection $\Box$	Post Adoption $\Box$
		Delinquency $\Box$	Assessment $\Box$
Services?	Voluntary Services $\Box$	Post Adoption Services $\Box$	Family Service Worker $\Box$
In home services? Yes 🗌 No 🗌 If yes, please specify:			
DCYF Worke	er:	Phone:	
Education	al services		
Is the youth	n enrolled in pre-k or school? Yes $\square$	No 🗆	
School:		District:	
Does the youth receive school services Yes $\Box$ No $\Box$			
School services (specify IEP or 504 plan):			
Primary and	d secondary IEP coding, if applicable:		

Date(s)

School contact person & role:

Contact number for school contact:

Developmental disability services
Is youth receiving developmental disability services? Yes 🗌 No 🗌 If yes, describe:
Provider: Provider's agency:
Provider contact:
Social/other services
Did the youth/family receive any of the following in the last 12 months (check all that apply) Medicaid  Supplemental Security Income (SSI)  Food Stamps  Women, infant, and children (WIC) Private insurance  Temporary assistance to needy families (TANF)  Other  Describe:
Medical/physical conditions
Ongoing medical conditions: Yes 🗆 No 🗆
If Yes, please describe:
Accommodations needed? Yes 🗌 No 🗌 If yes, please explain:
Medication Allergies: Yes 🗆 No 🗆
If Yes, please describe:
What does youth/family hope – and expect – to get from wraparound?
What would help the youth/family to participate and engage in wraparound?
Additional notes or comments

# To be completed by the Intake/Eligibility Coordinator:

Does the youth/family meet the eligibility criteria?		No
Between the ages of 5-21		
Designation of serious emotional disturbance (SED) or at-risk of SED		
Multi-system involved (e.g., mental health, educational, medical, developmental disability, JJ, DCYF)		
Non-responsive to existing school or community-based services		
Medicaid/Home and Community Based Care (HCBC) Eligible		

Family needs and circumstances	Low	Moderate	High
Need for immediate front-end stabilization			
Complexity of youth/family situation			
Barriers/capacity to engage right now			
Understanding of wraparound			
Hopes/expectations for wraparound			

Explanatory comments and notes