NH Early Childhood Wraparound Intake and Needs Based Eligibility Form

Please complete this form to the best of your abilities
Send form to: earlychildhoodbh@dhhs.nh.gov or fax to: 603-271-5040

Referral Information

Referral date: Referring organization: Referrer name:

Referrer phone number:

Referrer email: Referral type: --Select--

If referral type is "Other," please specify:

Is the family aware of the referral? --Select-- Has the family consented to referral? --Select--

Managed care organization:

Other insurance: Has MCO been engaged? --Select--

Medicaid ID: Insurance #:

Child Identification

Child's first name: Middle initial: Last name:

Preferred name: Personal pronoun: --Select-- Date of birth: Age:

Preferred written language: Translator needed? Yes ☐ No ☐

Preferred spoken language: Interpreter needed? Yes ☐ No ☐

Other accommodations? --Select If yes, explain:

Child Living Situation

Child living situation: --Select--

If "Other" living situation, please specify:

Child's street address:

City/town: State: New Hampshire (NH)

Zip code:

Are there weapons in the home? --Select--

If yes, how secured?

Is there a parenting plan in place? --Select--

Note regarding parenting plan

Child Demographics

What sex was child assigned at birth? --Select--

Is the child of Hispanic, Latino/a, or Spanish origin? --Select--

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

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

Which of the following race(s) best describe the child? (select all that apply)

- ☐ African American/Black
- ☐ Alaskan Native
- ☐ American Indian
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Guamanian Chomorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ Other Asian
- ☐ Other Pacific Islander
- ☐ Declined
- ☐ Unknown

Caregivers, family members, and other important people

Caregiver 1

Caregiver 1 First name _____ Last name _____

Preferred name _____

Caregiver 1 - Relationship to child --Select--

Preferred written language: _____ Translator needed? --Select--

Preferred spoken language: _____ Interpreter needed? --Select--

Mobile number: _____ Okay to text? --Select--

Email address: _____

Street address: _____

City/town: _____ State: --Select--

Zip code: _____

Other accommodations? --Select-- If yes, please explain: _____

Caregiver 2

Caregiver 2 First name | Last name

Preferred name

Caregiver 2 - Relationship to child --Select--

Preferred written language: | Translator needed? --Select--

Preferred spoken language: | Interpreter needed? --Selec

Mobile number: | Okay to text? --Select--

Email address:

Street address:

City/town: | State: --Select--

Zip code:

Other accommodations? --Select-- | If yes, please explain:

Other family members, relatives, and important people

Please provide name, relationship with child, and contact information below

Child & Family Strengths

What are the child and family best at? What does the child/family like to do? What helps them when times are tough? Who can they count on for support? (CANS Identified Strengths)

Is the child involved in any pro-social activities/groups? --Select--

List the activities and their frequency

Child Needs:

(Check all that apply)

- [ ] Behavior (e.g., excessive tantrums, biting, aggression, hitting, kicking)
- [ ] Learning/School readiness
- [ ] Eating and sleeping
- [ ] History of trauma/abuse/neglect
- [ ] Physical development
- [ ] Medical conditions
- [ ] Social Emotional development
- [ ] Separation from primary caregiver/attachment difficulties
- [ ] Language development
- [ ] Born Substance-exposed
- [ ] Other (Specify):

If any of the above requires an explanation, please include it here or provide supplemental documentation

Child's current primary psychiatric diagnosis:

Diagnostic code(s):

Historical psychiatric diagnoses:

Caregiver Needs:

(Check all that apply)

- [ ] Supervision
- [ ] Involvement with care
- [ ] Knowledge
- [ ] Organization
- [ ] Social resources
- [ ] Residential stability
- [ ] Medical/physical
- [ ] Mental health (SMI/SPMI)
- [ ] Accessibility to Child care
- [ ] Military transitions
- [ ] Child safety
- [ ] Substance use/early recovery
- [ ] Family stress
- [ ] Other (Specify)

If any of the above requires an explanation, please include it here or provide supplemental documentation

ACES

Child ACES

Which of the following has the child ***ever*** experienced in their lifetime? (Check all that apply)

- [ ] Was neglected or did not receive appropriate care (not enough to eat, had to wear dirty clothes, no one to protect or take care of them)
- [ ] Lost a parent or caregiver through separation, divorce, abandonment, death, or another reason
- [ ] Lived with a parent/caregiver who was depressed, mentally ill, or attempted suicide
- [ ] Lived with someone who had a problem with drinking or using drugs, including prescription drugs
- [ ] Lived with parents or caregivers that hit, punched, beat, or threatened to harm each other
- [ ] Lived with a parent or caregiver who went to jail or prison

Child ACES (*Continued . . .*)

- [ ] Lived with a parent or caregiver that swore at, insulted, or put them down
- [ ] Lived with a parent or caregiver that hit, beat, kicked, or physically hurt them
- [ ] Felt unsupported, unloved, or that nobody thought they were special
- [ ] Experienced unwanted sexual contact/abuse (such as fondling or oral/anal/vaginal intercourse/penetration)

Any other adverse childhood experiences (Please explain)

Caregiver ACES

Which of the following did the primary caregiver ***ever*** experience before the age of 18? (Check all that apply)

- [ ] Was physically neglected or did not receive appropriate care (not enough to eat, had to wear dirty clothes, no one to protect or take care of them)
- [ ] Lost a parent or caregiver through separation, divorce, abandonment, death, or another reason
- [ ] Lived with a parent or caregiver who was depressed, mentally ill, or attempted suicide
- [ ] Lived with a parent or caregiver who had a problem with drinking or using drugs, including prescription drugs
- [ ] Lived with parents or caregivers that hit, punched, beat, or threatened to harm each other
- [ ] Lived with a parent or caregiver who went to jail or prison
- [ ] Lived with a parent or caregiver that swore at, insulted, or put them down
- [ ] Lived with a parent or caregiver that hit, beat, kicked, or physically hurt them
- [ ] Felt unsupported, unloved, or that nobody thought they were special
- [ ] Experienced unwanted sexual contact/abuse (such as fondling or oral/anal/vaginal intercourse/penetration)

Any other adverse childhood experiences (Please explain)

ED utilization, hospitalization, and residential treatment

How many times has the family contacted Rapid Response or 911 for behavioral/mental health/psychiatric reasons in the past 12 months?

Was Rapid Response deployed? --Select-- If yes, how many times?

How many times has the child gone to the emergency room for behavioral/mental health/psychiatric reasons in the past 12 months?

How many times has the child been hospitalized for behavioral/mental health/psychiatric reasons in the past 12 months?

How many times has the child been hospitalized for behavioral/mental health/psychiatric reasons in their lifetime?

When was the child's most recent hospitalization for behavioral/mental health/psychiatric reasons?

Has the child ever been in an out-of-home placement? Include foster care, relatives, group home, residential treatment, detention or emergency shelter, etc. --Select--

If the child has been in an out-of-home treatment setting, please list settings, reason, and dates

Current behavioral health services

Is the child currently receiving behavioral health services? --Select--

Where is the child receiving behavioral health services? (Choose all that apply)

School ☐ Primary care ☐ Clinic/office/agency ☐ In home ☐ Other ☐

If "other" please describe

From what type(s) of agency(ies) is the child receiving services? (Choose all that apply)

School ☐ Primary care ☐ SUD agency ☐ ISO/HBT agency ☐

Community mental health center ☐ Private mental health center ☐ Other ☐

If "other" please describe

Therapist contact information

Name: Phone: Email:

Psychiatric provider contact information

Name: Phone: Email:

Case manager contact information

Name: Phone: Email:

Additional information about Hx of services/supports

Current DCYF services

Is the child or youth currently involved with DCYF? --Select--

Type of DCYF service(s) (Choose all that apply)

Child protection ☐ Post-adoption ☐

DCYF case type (Choose all that apply)

Abuse ☐ Neglect ☐ Guardianship ☐ Voluntary case ☐ Other ☐

"Other," please specify:

Current child abuse/neglect assessment? --Select--

Please describe:

Current in-home services? --Select--

Please specify:

Does the child have an upcoming court hearing? --Select-- Date of next court hearing:

DCYF name:

DCYF phone:

DCYF email:

Family-centered early supports and services

Is the child/family receiving early supports and services (Early Intervention)? --Select--

Name of provider

What services are the child/family receiving?

Is child/family receiving any Home Visiting services (e.g., Healthy Families America (HFA), Early Head Start, etc)? --Select--

What are the Home Visiting services? (if applicable)

Is child enrolled in daycare? --Select--

If so, what agency is providing daycare?

Current school-based/educational supports and services

Is child enrolled in school (Pre-K to 1)? --Select-- District: School:

What grade is the child in? --Select--

Does the child receive school services? --Select-- What type of services? --Select--

Primary and secondary IEP coding:

School contact name School contact role

School contact phone School contact email

Developmental services

Has the child been identified with a developmental disability? --Select--

Is child receiving developmental disability services? --Select--

If yes, describe

Area agency --Select-- Agency contact name

Provider Provider's agency

Provider contact Provider's email

Social/other services

Did the child/family receive any of the following in the last 12 months (select all that apply)

- ☐ Medicaid
- ☐ Supplemental Security Income (SSI)
- ☐ SNAP benefits
- ☐ Other
- ☐ Women, infants, and children (WIC)
- ☐ Temporary Assistance for Needy Families (TANF)
- ☐ Private insurance

If "other," please specify

Medical conditions and services

Ongoing medical conditions --Select-- If yes, please describe

Accommodations needed --Select-- If yes, please describe

Medication allergies --Select-- If yes, please describe

Expectation and engagement

What does child/family hope - and expect - to get from this program?

What would help the child/family to participate and engage in this program?

Additional notes or comments