



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

Form CBH002

PD24-01

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

Last updated: 2024.05.14

Referral Information

Referral date: Referring organization: Referrer name:

Referrer phone number:

Referrer email: Referral type:

If referral type is "Other," please specify:

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

Managed care organization:

Other insurance: Has MCO been engaged?

Medicaid ID: Insurance #:

Youth Identification

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

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

Preferred written language: Translator needed? Yes No

Preferred spoken language: Interpreter needed? Yes No

Other accommodations? If yes, explain:

Youth Living Situation

Youth living situation:

If "Other" living situation, please specify:

Child's street address:

City/town: State:

Zip code:

Are there weapons in the home?

If yes, how secured?

Is there a parenting plan in place?

Notes regarding parenting plan:

Youth Demographics

Youth's current gender identity (Select all that apply)

Girl/woman

Boy/man

Something else (e.g., non-binary, genderqueer, genderfluid)

Transgender girl/woman

Transgender boy/man

Choose not to disclose

Youth's current sexual orientation (Select one)

Bisexual

Gay or lesbian

Straight or heterosexual

Something else (e.g., queer, pansexual, asexual)

Don't know

Choose not to disclose

What sex was youth assigned at birth?

Is the youth of Hispanic, Latino/a, or Spanish origin?

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

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

African American/Black

Guamanian Chomorro

White

Alaskan Native

Japanese

Other Asian

American Indian

Korean

Other Pacific Islander

Asian Indian

Native Hawaiian

Declined

Chinese

Samoaan

Unknown

Filipino

Vietnamese

Caregivers, family members, and other important people

Caregiver 1

Caregiver 1 First name

Last name

Preferred name

Caregiver 1 - Relationship to youth

Preferred written language:

Translator needed?

Preferred spoken language:

Interpreter needed?

Mobile number:

Okay to text?

Email address:

Street address:

Caregiver 1 *(Continued . . .)*

City/town:

State:

Zip code:

Other accommodations:

If yes, please explain:

Caregiver 2

Caregiver 2 First name

Last name

Preferred name

Caregiver 2 - Relationship to youth

Preferred written language:

Translator needed?

Preferred spoken language:

Interpreter needed?

Mobile number:

Okay to text?

Email address:

Street address:

City/town:

State:

Zip code:

Other accommodations?

If yes, please explain:

Other family members, relatives, and important people

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

Youth & 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? (CANS Identified Strengths)

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

List the activities and their frequency

Child/youth needs:

Behavioral/Emotional (Check all that apply)

Adjustment to trauma

Anxiety

Autism spectrum/developmental disability

Depression

Eating disturbance

Emotional regulation/anger control

Grief, loss

Impulsivity, hyperactivity, attention challenges

Sleep disturbance

Substance misuse

Symptoms of psychosis

Oppositional, defiant, conduct

Life Functioning (Check all that apply)

Family concerns, attachment problems

Medical/physical concerns

Sexual development concerns

Social/friendship concerns

School/vocational concerns

Risk behaviors (Check all that apply)

Danger to self (suicide, self-injury, self-harm)

Danger to others (violent/aggressive/homicidal ideation or behavior, sexual aggression, etc.)

Delinquent behavior (rule breaking, truancy, firesetting, animal cruelty, intentional misbehavior, etc.)

Other (Please explain):

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

Other, please explain

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

Youth ACES

Which of the following ACES has the youth 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

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)

Other adverse experiences:

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?

If yes, how many times?

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

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

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

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

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

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

Current behavioral health services

Is the youth currently receiving behavioral health services?

Where is the youth 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 prior services/supports

Current DCYF services

Is the child or youth currently involved with DCYF?

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

Child protection Juvenile justice Post-adoption

DCYF case type (Choose all that apply)

Abuse Neglect Guardianship Voluntary case CHINS
Delinquency HOPE Other

If "other," please specify:

Current child abuse/neglect/Juvenile justice assessment?

Please describe:

Current in-home services?

Please specify:

Does the youth have an upcoming court hearing?

Date of next court hearing:

DCYF worker contact information

Name: Phone: Email:

Additional DCYF worker contact information

Name: Phone: Email:

Current school-based/educational supports and services

Is youth enrolled in school (K-12)?

District:

School:

What grade is the youth in?

Does the youth receive school services?

What type of services?

Primary and secondary IEP coding:

School contact information

Name: Role: Phone: Email:

Developmental services

Has the youth been identified with a developmental disability?

Is youth receiving developmental disability services?

If yes, describe

Developmental services *(Continued . . .)*

Area agency

Agency contact name

Provider's agency

Provider

Provider's email

Provider contact

Social/other services

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

Medicaid

Women, infants, and children (WIC)

Supplemental Security Income (SSI)

Temporary Assistance for Needy Families (TANF)

SNAP

Private insurance

Other

If "other," please specify

Medical conditions and services

Ongoing medical conditions

If yes, please describe

Accommodations needed

If yes, please describe

Medication allergies

If yes, please describe

Expectation and engagement

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

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

Additional notes or comments