CHOICES INITIAL SCREENING FOR WRAPAROUND CARE COORDINATION

Fax to: 866-252-7174 Attn: Lindsay Bergman

Youth Name:	DOB:	Age:
Address:	Gender:	Race:
City and Zip Code:	County:	Date:
Current Residency:	SS #:	
Parent/Guardian:	Relationship:	Phone #:
Current Caregiver:	Relationship:	Phone #:
Referral Name:	Agency:	Phone #:
Medicaid ID #:	In CPS Custody? ◯ Yes ◉ No	

If in CPS Custody: Who is the authorized representative:

What is the current permanency plan?

What has recently happened to increase the youths risk for out-of-home placement?

What specific behaviors are occurring that places the youth and family at risk?

◯ Yes ◉ No Do you think this youth is at risk of being admitted into a Psychiatric Residential Treatment Facility (PRTF)? If yes, why?

◯ Yes ◉ No Has the youth ever required/received acute psychiatric care? If yes, when & where?

◯ Yes ◉ No Has the youth ever received outpatient mental health services? If yes, when & where?

◯ Yes ◉ No Is the youth under the care of a psychiatrist/psychologist? If yes, who & where?

◯ Yes ◉ No Is the youth under the care of a primary care physicians? If yes, who & where?

◯ Yes ◉ No Has the youth ever been diagnosed with any type of Serious Emotional Disorder (SED)? If yes, provide diagnosis.

◯ Yes ◉ No Does the youth regularly take any prescription drugs? If yes, please list them.

Youth Name:

***School Setting**:*

School Name: Grade: Preferred Contact:

Does the youth experience problems now or in the past with…

☐Yes☐No School attendance?

☐Yes☐No Disciplinary actions?

☐Yes☐No Poor grades?

☐Yes☐No Does the youth have an IEP?

Juvenile Justice System: Does the youth experience problems now or in the past with…

☐Yes☐No Being arrested? If yes, what was the charge?

☐Yes☐No Being placed in the detention center? If yes, list dates:

☐Yes☐No Being placed on youth court probation?

If yes, Counselor Name: Phone Number:

Drug or Alcohol Abuse: Does the youth experience now or in the past with…

☐Yes☐No Drugs or alcohol? If yes, list drug of choices:

☐Yes☐No Relationships or school being affected by use?

☐Yes☐No Received treatment for substance abuse? If yes, when & where?

☐Yes☐No Has the youth been observed using drugs or alcohol by you or reported by others?

Safety/Risk Factors: Does the youth experience problems now or in the past with…

☐Yes☐No Threatening or attempting to harm self or other?

☐Yes☐No Self-harming behaviors (cutting, scratching, burning, etc.)

☐Yes☐No Sexual acting out?

Family Functioning Issues: Does the youth experience problems now or in the past with…

☐Yes☐No Abuse and/or neglect?

☐Yes☐No Running away from home? If yes, for how long & to where?

☐Yes☐No Causing severe strain on the family/family relationships?

Please check if either of the following apply:

☐I have provided the family a brochure on Choices Wraparound services.

☐I have reviewed the Choices website regarding Wraparound services with the family.

Reviewed by: Date:

Initial Screening Requirements Met? ○Yes ◉No

If no, was the referral source provided with other options for treatment? ○Yes ◉No