



NH Early Childhood Wraparound Intake and Needs Based Eligibility Form

Please complete this form to the best of your abilities

Referral Information

Referral date: Referring organization: Referrer name:
Referrer relationship to child: 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: BCBH ID: Insurance #:

Child Identification

Child's first name: Middle name: 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:

Child Living Situation

Child 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?

Child Demographics

What sex was child assigned at birth?

Is the child 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 child? (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 Middle name Last name

Preferred name

Caregiver 1 - Relationship to child Caregiver 1 - personal pronoun

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:

Caregiver 2

Caregiver 2 First name Middle name Last name

Preferred name

Caregiver 2 - Relationship to child

Caregiver 2 - personal pronoun

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

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?

List the activities and their frequency

Concerns about child's:

(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 (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:

Concerns about caregiver's:

(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

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?

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

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

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 their lifetime?

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

If the child has been in an out-of-home treatment setting, please list them.

Current behavioral health services

Is the child currently receiving behavioral health services?

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

School Primary care Clinic/office/agency In home Other

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 name:

Therapist phone:

Therapist email:

Psychiatric provider name:

Psychiatric provider phone:

Psychiatric provider email:

Case manager name:

Case manager phone:

Case manager email:

Additional information about Hx of 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 CHINS

Court-ordered CHINS

Delinquency

HOPE

"Other," please specify:

Current child abuse/neglect assessment?

Please describe:

Current in-home services?

Please specify:

Does the child have an upcoming court hearing?

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)?

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)?

What are the Home Visiting services? (if applicable)

Is child enrolled in daycare or pre-k?

Is so, what agency/district is providing daycare/pre-k?

Current school-based/educational supports and services

Is child enrolled in school (K-12)? District: School:

What grade is the child in?

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

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?

What is the child's disability? Child's IQ

Is child receiving developmental disability services?

If yes, describe

Area agency 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	Women, infants, and children (WIC)
Supplemental Security Income	Temporary Assistance for Needy Families (TANF)
(SSI) SNAP benefits	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 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