# Wraparound: (SNCD)
## Strengths, Needs, Culture, Discovery

| **Client Name/ID** (or affix label) | **DOB:** |
|---|---|
| _____ | **Assessment Date:** |

**Parent / Family Questions** ***(please type all responses)***

**1. Who lives in your home at this time?** ***(family e.g., genogram and living/residence)***

**2. What do you like best about your son / daughter?**

**3. Tell me about when your son / daughter was born. When did they walk, talk, become potty trained, etc.?** ***(gather developmental history)***

**4. With regard to your family, what are you most proud of?** ***(current family situation)***

**5. How does your family enjoy time together?** ***(current family situation)***

**6. Describe your best quality as a parent. What is your parenting style?** ***(current family situation)***

**7. Tell me about how you were raised. As a parent, are you similar or different from your parents? (*family history)***

**8. Does your family belong to any faith community? Who in your family participates in this faith community?** ***(spiritual, cultural, natural supports)***

**9. Who were the last three visitors in your home?** ***(natural supports)***

**10. Who do you call when times are tough?** ***(natural supports)***

**11. Does your family celebrate holidays? Which ones and in what way?** ***(spiritual, cultural, natural supports)***

**12. How do you identify your culture? Could you tell me how this has affected you in a positive way?** ***(gather full cultural information including socioeconomic, geographic, ethnicity )***

**13. What about your neighborhood. Does everyone know each other or is it more private?** ***(living situation / residence)***

**14. How do you relax?** ***(self-care /social recreational)***

**15. What was / is the best job you ever had? Who were / are you closest to at work?** ***(regular / routine source of income, employment / education)***

**16. Are all of your family's basic needs being met (e.g., food (ability to obtain & prepare), housing (stability), clothing, transportation (access to), etc.)** ***(Life Domains)***

**17. If you could change anything in your life, what would it be?** ***(presenting problems, onset, intensity, frequency)***

**18. What are your immediate goals for your family?** ***(goals)***

**19. What are your long range goals for your family?** ***(goals)***

**20. What do you imagine your son / daughter's life will look like when they are 21? 40?** ***(goals)***

**Youth Questions (only)** ***(please type all responses)***

**21. Who is your favorite band or artist?** ***(social / recreational)***

**22. What types of things do you like to do with your friends?** ***(social / recreational)***

**23. What do you like about school? What is your favorite class?** ***(employment / education)***

**24. Name one thing you would like to get better at.** ***(goals)***

**25. What are your responsibilities at home?** ***(living situation / residence)***

**26. Name someone who is important to you and why?** ***(natural supports)***

**27. Who do you get along with in your family? Who do you have struggles with?** ***(current family situation)***

**28. If you could change one thing about your family, what would it be?** ***(goals)***

**29. If you could change one thing about yourself, what would it be?** ***(presenting problems, onset, intensity, frequency)***

**30. Name one thing you want to do with your life no matter what.** ***(goals)***

# Wraparound:
## Mental Health Assessment

***(please type all responses)***

**Diagnosis (code and name)**

**Axis I** _____

_____

_____

**Axis II** _____

_____

_____

**Axis III** _____

***(Please check all that apply and elaborate on each)***

**Axis IV** ☐1-Prim Suppt ☐2-Social ☐3-Education ☐4-Occupation ☐5-Housing ☐6-Economic ☐7-Health ☐8-Legal ☐9-Other

***(Please type all responses below)***

_____

**Axis V** _____GAF (Adult 18+) _____ CGAS (Child / Youth 6 -17) _____ PIR-GAS (Child under 5)

*Note for Data Entry staff: If **PRIMARY** Diagnosis for Axis I is a rule out, type **ruleout** into Additional Info field in NSMHA Authorization Request screen.*

**Diagnostic Summary**

*Include a brief demographic description and a complete **diagnostic justification:***

- *Include all justifying information from the DSM – both symptoms and duration.*
- *When appropriate, include how another diagnosis was ruled out.*
- *Explain any differences in diagnosis if client has a diagnosis from another source such as a hospital or PCP, especially if client is being prescribed medication for the other provider's diagnosis.*
- *Include justification for the GAF/CGAS/PIRGAS.*

*Include risk factors for B list diagnoses*

***(MHP Diagnostic Summary)***

## Eligibility

*An individual must meet **all of the following** in order to be eligible for mental health services..*

- ☐ Impairment and corresponding need(s) are the result of a mental illness.
- ☐ Intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness.
- ☐ The client is expected to benefit from the intervention.
- ☐ The unmet need would not be more appropriately met by any other formal or informal system or support.
- ☐ GAF/CGAS Below 60
- ☐ Covered Diagnosis ("A" diagnosis or "B" with qualifiers)

*Is Primary Diagnosis a "B" Diagnosis?* ☐ *yes* ☐ *no*

*If yes, complete this section to indicate what risk factors apply. Choose at least one box from the list.*

| | | |
|---|---|---|
| Young Adults or Children age 6 and above | ☐ | High risk behavior demonstrated during the previous 90 days – aggressive and/or dangerous, puts self or others at risk of harm, is at risk of severe functional deterioration, is at risk of hospitalization or at risk of loss of current placement due to mental illness or at risk of out of home placement due to the symptoms of an emotional disorder or mental illness; |
| | ☐ | Two or more hospital admissions due to a mental health diagnosis during the previous two years; |
| | ☐ | Psychiatric hospitalization or residential treatment due to a mental health diagnosis of more than six months duration in the previous year OR is currently being discharged from a psychiatric hospitalization; |
| | ☐ | Received public mental health treatment on an outpatient basis within the PIHP system during the previous 90 days and will deteriorate if services are not resumed (crisis intervention is not considered outpatient treatment); |
| Clients age 6-17 | ☐ | At risk of escalating symptoms due to repeated physical or sexual abuse or neglect and there is significant impairment in the adult caregiver's ability to adequately address the child's needs. |
| Clients under age 6 | ☐ | Atypical behavioral patterns as a result of an emotional disorder or mental illness (odd disruptive or dangerous behavior which is aggressive, self-injurious, or hypersexual; display of indiscriminate sociability/excessive familiarity with strangers). |
| | ☐ | Atypical emotional response patterns as a result of an emotional disorder or mental illness which interferes with the child's functioning (e.g. inability to communicate emotional needs; inability to tolerate age-appropriate frustrations; lack of positive interest in adults and peers or a failure to initiate or respond to most social interaction; fearfulness or other distress that doesn't respond to comfort from caregivers). |

☐ Client meets eligibility criteria, CALOCUS/LOCUS attached – submit Authorization Request (via Raintree)

☐ Client does *not* meet eligibility criteria - Submit Denial Review Request (via Fax)

*The day after Access Call is Day 1.*

Access call date _____ (day __0__)

Assessment date_____ (day _____)

Received by support staff_____ (day _____)

Data entry complete _____ (day _____)*

*If data entry completed *after* day 13, must document reason.

If reasons already explained in Raintree (no-shows, cancellations, reschedules, etc) cut and paste from Admit Notes Screen.

_____

If reasons not explained in Raintree, enter text explaining why in the Reasons for Delay field. Some examples:

- Assessment was scheduled toward the end of the 10 business day timeline, and unable to complete assessment paperwork and data entry within the 13 day window.
- Face to face assessment occurred within first 13 days but additional information was needed for completion.
- Denial Review Request submitted and NSMHA overturned request, client is to be admitted.

**Mental Health Treatment and Health History** ***(please type all responses)***

☐ Client has no history of past mental health treatment – or –

☐ Dates and places of previous outpatient and inpatient treatment:

☐ Does anyone else in your family have a history of mental health issues? ***(describe)***

**Health and Medical History** ***(please type all responses)***

☐ Current and past medications used if any.

☐ Are there any current dental or health needs?

☐ Client presents at Assessment with an EPSDT referral from PCP.

☐ Last physical within 2 years, no EPSDT referral needed.

☐ Has no PCP, gave Benefits Booklet / EPSDT referral letter.

☐ Has PCP, last physical more than 2 years, gave EPSDT referral letter.

**Substance Abuse Screening** (GAIN-SS required age 13 y.o. or older)

| | No | Yes |
|---|---|---|
| 1. Does the client misuse prescription/street drugs or alcohol to cope with life? If yes, is client willing to get treatment? ☐ Yes ☐ No If a referral was made, indicate where:_____ | ☐ | ☐ |
| 2. Do others think the client has a substance use problem? | ☐ | ☐ |
| 3. Do family members have a history of substance use/abuse? | ☐ | ☐ |
| 4. Has client's and/or family member's substance use ever led to family, legal or work/school problems? | ☐ | ☐ |
| 5. Has the client ever received outpatient/inpatient drug/alcohol treatment? | ☐ | ☐ |

**Comments** *(required for ALL yes answers in this section):* ***(please type all responses)***

**Stage of Change** *required if client has a positive screen on the GAIN-SS (scores 2 or more in the IDS or EDS sections and 2 or more in the SDS section) - otherwise optional*

Clinician's assessment of client's state of change for:

**Mental Health Issues**

☐ No problem and/or no interest in change (Pre-contemplation)
☐ Might be a problem; might consider change (Contemplation)
☐ Definitely a problem; getting ready to change (Preparation)
☐ Actively working on changing, even if slowly (Action)
☐ Has achieved stability, and is trying to maintain (Maintenance)

**Comments, if any:** ***(please type all responses)***

**Chemical Dependency Issues**

☐ No problem and/or no interest in change (Pre-contemplation)
☐ Might be a problem; might consider change (Contemplation)
☐ Definitely a problem; getting ready to change (Preparation)
☐ Actively working on changing, even if slowly (Action)
☐ Has achieved stability, and is trying to maintain (Maintenance)

**Comments, if any:** ***(please type all responses)***

## Risk Management/Safety and Stability *(please type all responses and mark any boxes that apply and comment):*

☐ *No known risk factors (skip this section)*_____

| ☐ *Self-Harm/Suicidal ideation/attempts (comments)* | Current | | | History | | |
|---|---|---|---|---|---|---|
| | | *Yes* | *Denied* | | *Yes* | *Denied* |
| | *Ideation* | ☐ | ☐ | *Ideation* | ☐ | ☐ |
| | *Plan* | ☐ | ☐ | *Plan* | ☐ | ☐ |
| | *Attempts* | ☐ | ☐ | *Attempts* | ☐ | ☐ |
| ☐ *At risk for harming others (comments)* | Current | | | History | | |
| | | *Yes* | *Denied* | | *Yes* | *Denied* |
| | *Ideation* | ☐ | ☐ | *Ideation* | ☐ | ☐ |
| | *Plan* | ☐ | ☐ | *Plan* | ☐ | ☐ |
| | *Attempts* | ☐ | ☐ | *Attempts* | ☐ | ☐ |

*Except where "history" is noted, indicate **current** risks:*

☐ History of psychiatric hospitalization_____

☐ Homelessness_____

☐ History of trauma/victimization *(sexual abuse, domestic violence, etc.)*_____

_____

☐ Multiple residential placements *(foster homes, Adult Family Homes, etc.)*_____

_____

☐ Medication non-compliance_____

☐ Separation from family/natural supports_____

☐ Property destruction_____

☐ Physical Disability/other medical condition_____

☐ Sexual aggression_____

☐ Running away_____

☐ Criminal behavior/Court Order/Legal Issues_____

☐ CPS/APS Involvement_____

☐ Not safe for outreach (*weapons in home?)*_____

☐ Other_____

_____

**Complete interim plan for any risk factors that should be addressed prior to Crisis Plan completion**

☐ *NO URGENT RISK FACTORS TO BE ADDRESSED TODAY*
☐ Review roles of Natural Supports_____
☐ Complete ROI's as needed_____
☐ No Harm Contract/Safety Plan_____
☐ Provided Crisis Line Number_____
☐ Crisis Alert_____
☐ Refer for ES Psych appointment_____

☐ ***Other Plan(s)***_____

_____

_____

## ***Mental Status Examination*** (at time of interview - consider cultural norms in completing this section)

***Appearance***
- ☐ Age/culture appropriate
- ☐ Meticulous
- ☐ Unkempt
- ☐ Inappropriate
- ☐ Eccentric
- ☐ Poor Hygiene

Children Only:
- ☐ Age/size congruent
- ☐ Slumped
- ☐ Relaxed
- ☐ Rigid/tense
- ☐ Other:

Comments:

***Thought Processes***
- ☐ Age/culture appropriate
- ☐ Circumstantial
- ☐ Concrete
- ☐ Tangential
- ☐ Aggressive
- ☐ Obsessive
- ☐ Phobias
- ☐ Blocking
- ☐ Paranoid Ideation (specify)
- ☐ Delusions (specify)
- ☐ Other:

***Orientation***
- ☐ Age/culture appropriate
- ☐ Disorientated to:
  - ☐ Person
  - ☐ Place
  - ☐ Date
  - ☐ Situation

***Mood/Affect***
- ☐ Age/culture appropriate
- ☐ Flat/blunted
- ☐ Labile
- ☐ Incongruent
- ☐ Depressed
- ☐ Expansive
- ☐ Anxious/fearful
- ☐ Angry
- ☐ Other:

***Cognitive Functioning***

Remote Memory
- ☐ Present
- ☐ Limited

Recent Memory
- ☐ Present
- ☐ Limited

Ability to Abstract
- ☐ Present
- ☐ Limited

***Motor Activity***
- ☐ Age/culture appropriate
- ☐ Agitated
- ☐ Hyperactive
- ☐ Lack of movement
- ☐ Tremors
- ☐ Tics
- ☐ Mannerisms
- ☐ Facial grimacing
- ☐ Other:

***Perceptual Processes***
- ☐ Age/culture appropriate
- ☐ Imagination (child only)
- ☐ Depersonalization
- ☐ Hallucinations (specify):
  - ☐ Auditory
  - ☐ Visual
  - ☐ Tactile
  - ☐ Olfactory
  - ☐ Somatic
  - ☐ Other:

***Insight/Judgment***
- ☐ Age/culture appropriate
- ☐ Understands consequences
- ☐ Denial/resistance
- ☐ Blames others
- ☐ Aware of problem
- ☐ Poor impulse control
- ☐ Discern right/wrong

***Behavior***
- ☐ Age/culture appropriate
- ☐ Poor eye contact
- ☐ Attends to task
- ☐ Distractible
- ☐ Cooperative
- ☐ Friendly
- ☐ Withdrawn/passive
- ☐ Suspicious
- ☐ Guarded
- ☐ Ingratiating
- ☐ Hostile
- ☐ Bizarre

Verbally:
- ☐ Interacts
- ☐ Initiates
- ☐ Interrupts
- ☐ Redirects

Children Only:
- ☐ Separation reactions (specify):

- ☐ Other:

***Speech***
- ☐ Age/culture appropriate
- ☐ Slow
- ☐ Rapid
- ☐ Soft
- ☐ Loud
- ☐ Mute
- ☐ Profuse
- ☐ Pressured
- ☐ Age Intelligible
- ☐ Unintelligible
- ☐ Impaired/medical condition:
- ☐ Slurred
- ☐ Mumbled
- ☐ Clear
- ☐ Whiny
- ☐ Blocked
- ☐ Perseverations
- ☐ Stuttering
- ☐ Other:

***Sleep***
- ☐ Adequate
- ☐ Decreased
- ☐ Increased
- ☐ Other

***Appetite***
- ☐ Adequate
- ☐ Decreased
- ☐ Increased
- ☐ Weight Change

## Assessment Clinician's Recommendations / Interim Treatment Plan

Special Population Status: ☐ Child / Youth ☐ DD ☐ Deaf ☐ African American ☐ Asian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Hispanic

*Provide treatment "orders" for next 30 days, or until Wraparound Plan is completed by the Wraparound Team Be sure to order all medically necessary services that may fall within that period.*

☐ Client not eligible for services; referred to external resources

| | | |
|---|---|---|
| ☐ | Individual Psychotherapy/Beh Health Counseling | Frequency:_____ |
| ☐ | Comprehensive Community Support | Frequency:_____ |
| ☐ | Initial Psychiatric Diagnostic Eval | Frequency:_____ |
| ☐ | Group Psychotherapy | Frequency:_____ |
| ☐ | Group Patient Education | Frequency:_____ |
| ☐ | Family Therapy | Frequency: _____ |
| ☐ | MH Services in a Residential Setting | Frequency: _____ |
| ☐ | High Intensity Treatment Team | Frequency: _____ |
| ☐ | Other (specify) _____ | Frequency:_____ |
| ☐ | Other (specify) _____ | Frequency:_____ |

Additional recommendations: ***(please type all responses)***

☐ See Risk Section for interim risk factor plan

_____ _____

Assessor Signature, Degree/Specialty/ID Date Printed Name

_____ _____

MHP Supervisor Signature, Degree/Specialty/ ID (if needed) Printed Name