** WRAP SCREENING SHEET**

**Date of Screening:** Click here to enter a date.

Client: Click here to enter text.

DOB/Age: Click here to enter text.

OHP Member ID: Click here to enter text.

Parent: Click here to enter text.

Phone: Click here to enter text.

Address: Click here to enter text.

Guardian: Click here to enter text.

Phone: Click here to enter text.

Address: Click here to enter text.

Referring Agency/Therapist: Click here to enter text.

Diagnosis: Click here to enter text.

Current behavioral symptoms: Click here to enter text.

Treatment History: Click here to enter text.

Trauma History: Click here to enter text.

**Wraparound Criteria:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Age 0-17 Trillium Medicaid Enrolled : | | | | ☐ | |
| Explained Wrap to Family Who Agree to Participate: | | | | ☐ | |
| Involvement in Two or More of the Following Systems: | | | | | | |
| MH: | ☐ | Click here to enter text. | | | | |
| * Step Down from Residential in the last 6 months | | | ☐ | | Click here to enter text. | |
| DD: | ☐ | Click here to enter text. | | | | |
| DYS: | ☐ | Click here to enter text. | | | | |
| SUD: | ☐ | Click here to enter text. | | | | |
| DHS: | ☐ | Click here to enter text. | | | | |
| School: | ☐ | Click here to enter text. | | | | |
| Medical: | ☐ | Click here to enter text. | | | | |

Anticipated Team Members (Professionals and/or natural supports that are already involved): Click here to enter text.

Return screening sheet to Trillium Behavioral Health: FAX 541-984-5692