



**DIVISION OF MEDICAID  
BUREAU OF MENTAL HEALTH PROGRAMS  
MYPAC INITIAL SCREENING**



**Fax to 601-359-6294 Attn: Bonlitha Windham**

Youth Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
 Address: \_\_\_\_\_ Gender: \_\_\_\_\_ Race: \_\_\_\_\_  
 City and Zip Code: \_\_\_\_\_ County: \_\_\_\_\_ Date: \_\_\_\_\_  
 Parent/Guardian: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Referral Name: \_\_\_\_\_ Agency: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Medicaid ID #: \_\_\_\_\_ SS #: \_\_\_\_\_  
 Current residency: \_\_\_\_\_ In DHS custody?  Yes  No

What has recently happened to cause the youth to need services?

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What is the primary behavioral issue that is prompting this referral?

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- Yes  No Do you think this youth is at risk to be admitted into a Psychiatric Residential Treatment Facility (PRTF)?

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- Yes  No Has the youth ever been in a PRTF? If yes, number of times, when, & where?

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

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- Yes  No Has the youth ever received services from a community mental health center? If yes, where and when?

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

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

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

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**School Setting: Does the youth experience problems now or in the past with ...**

- Yes  No school attendance?
- Yes  No disciplinary actions?
- Yes  No poor grades?

Youth Name \_\_\_\_\_

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

- Yes  No being arrested?
- Yes  No being placed in a detention center?
- Yes  No being placed on youth court probation?

**Drug or Alcohol Abuse: Does the youth experience problems now or in the past with ...**

- Yes  No drugs or alcohol?
- Yes  No relationships or school being affected by use?
- Yes  No Has the youth received treatment for substance abuse?
- Yes  No Has the youth been observed using drugs and 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 others?

**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?
- Yes  No causing severe strain on the family/family relationships?

***The following questions are to be answered by the parent/guardian of youth:***

What is your personal feeling about community-based service/support delivery (non-residential)?

- Yes  No Do you feel it would be a helpful and effective program for the youth?
- Yes  No Would you and the family be willing to actively participate and be supportive of the youth and the MYPAC community-based program?

- (check one)**  Yes, I want to apply for MYPAC services for this youth.  
 No, I do not want to apply for MYPAC services for this youth.

How did you hear about MYPAC? \_\_\_\_\_

Additional comments: \_\_\_\_\_

*(For DOM use only – please do not write below this line)*

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|--|-----------|------|
| Reviewed by: _____   | SIGNATURE | DATE |
| _____  | SIGNATURE | DATE |
| Initial Screening Requirements Met? <input type="checkbox"/> Yes <input type="checkbox"/> No                         |           |      |
| Referred to MYPAC Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provider name: _____    |           |      |
| If no, was the referral source provided with other options? <input type="checkbox"/> Yes <input type="checkbox"/> No |           |      |