MYPAC INITIAL SCREENING

Canopy Children's Solutions
P.O. Box 1078
Jackson, MS 39215
Office 601-352-7784 / Fax 601-709-1219
Attn: Jodie Wright (Admissions Coordinator)

Date: ______________________

Youth's Name: ________________________________

Date of Birth: ________________________________ Age: ________ Gender: ________ Race: ________

Social Security #: ________________________________ Medicaid #: __________________________________

Current Address ____

City: ________________________ County: ______________________ State: ___________ Zip: _________

Telephone # ____

In DHS Custody? YES ____ NO ____ If yes, Social Worker: ____

Social Worker Telephone: _________________________________ Email: _______________________________

Parent/Caregiver Name: __________________________________ Relationship to Youth: __________________

Address ____

City: ________________________ County: ______________________ State: ___________ Zip: _________

Telephone # ___________________________________ Cell Phone # ___________________________________

Email:____

Please check all solutions the youth has received from Canopy.

_____ MYPAC _____ in-CIRCLE _____TFC _____ Outpatient Solutions

_____ CARES _____ CARES School _____ Shelters ______ Other

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

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YES ____ NO ____	Has the youth ever applied for MYPAC services before? If yes, when and where?
YES ____ NO ____	Do you think this youth is at risk to be committed into a higher level of care, such as a Psychiatric Residential Treatment Facility (PRTF) or emergency hospitalization?
YES ____ NO ____	Has the youth ever received services from a residential inpatient or emergency hospitalization setting? If yes, then when and where?
YES ____ NO ____	Has the youth every received services from a community mental health center? If yes, when and where?
YES ____ NO ____	Has the youth ever been under the care of a psychiatrist or psychologist? If yes, when and where?
YES ____ NO ____	If the youth has had any type of behavioral diagnosis (i.e., Serious Emotional Disturbance (SED), of which you are aware, please list the diagnosis below.
YES ____ NO ____	Does this youth currently take any prescription drugs? If yes, please list below.
YES ____ NO ____	Has the youth received treatment for substance abuse?
YES ____ NO ____	Has the youth been observed using drugs or alcohol by you or reported by others?

School Setting – Has the youth experienced problems with any of the following?

YES ____ NO ____	School attendance
YES ____ NO ____	Disciplinary actions
YES ____ NO ____	Poor grades

Juvenile Justice System – Has the youth experienced problems with any of the following?

YES ____ NO ____	Being arrested
YES ____ NO ____	Being placed in a detention center

YES ____ NO ____	Being placed on youth court probation

Drug or Alcohol Abuse – Has the youth experienced problems with any of the following?

YES ____ NO ____	Drugs or alcohol
YES ____ NO ____	Relationships being affected by usage
YES ____ NO ____	School being affected by usage

Safety/Risk Factors – Has the youth experienced problems with any of the following?

YES ____ NO ____	Threatening or attempting to harm self.
YES ____ NO ____	Threatening or attempting to harm others.

Family Functioning Issues – Has the youth experienced problems with any of the following?

YES ____ NO ____	Abuse and/or neglect
YES ____ NO ____	Running away from home
YES ____ NO ____	Causing severe strain on the family/family relationship

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

YES ____ NO ____	Would you and the family be willing to actively participate and be supportive of the youth and the MYPAC community-based programs?
How did you hear about MYPAC?	

Referral Source Contact Information

Referral Name: ____

Agency: ____

Address ____

City: ______________________ State: __________ Zip: ___________

Telephone # ______________________