MIDWEST MONSTERS

Children's Long-Term Support Program

(Available Activities and Services)

Children's Long-Term Support: Covered Services | Wisconsin Department of Health Services

Medical Directors
Clinical Social Worker
Doctor
Individual Therapist
Psychotherapist
Psychologist
Psychiatrist
Registered Nurse
Direct Care Services
Mentoring & Tutoring
Transportation
Grief Counseling
Therapeutic Counseling
Stress Management
Anxiety Treatment
Child Care
Anger Management
Healthcare Management and Wellness
Depression Counseling
Cognitive Behavior
Respite Care
Day Services
Personal Support
Discovery and Career Planning
Substance Abuse

Social Fun Events
Housing Support Services
Traveling Certified CNAs and Traveling Certified Registered Nurses
Relocation Services (Affordable and Emergency Housing)
Home Modifications
Adult Family Home
Children's Foster Care
All Year Round Daily Activities
Free Hot Cooked Meals Program
Art Club
Urban Hip-Hop Dance Exposure Traveling Basketball Program
Gamer's Club (Members Only)
Football Program
Basketball Program
Pickleball Program
Culinary Arts Program
Community Service

All Year Round Daily Activities and Field Trips
Weekly and Weekends
Milwaukee County Zoo
Art and Field Museum
Action Territory
Wisconsin Dells
Sky Zone
Movie Theater
Ice Skating
State Fair
Wolf Lodge
Urban Air
Summerfest
Six Flags Great America
Juneteenth
Fourth of July

MENTAL HEALTH PLAN ASSESSMENT FORM

Every item must be completed.

Date_____ **Provider**_____**Phone**_____

Provider Office Address_____

Client Name _____ **D.O.B.**_____**SSN**_____

Consent to treat given by: ☐ Self ☐ Parent/Guardian ☐ Conservator

Referral ☐ Self ☐ School ☐ Probation ☐ Court ☐ CPS ☐ APS ☐ Parent/Guardian/Conservator ☐ Access Unit ☐ Other _____

Living Arrangement ☐ Own House ☐ Bio Family ☐ Foster Family ☐ Group Home ☐ SNF ☐ B&C

Ethnicity_____ **Language Preferred for Services**_____

Emergency Contact_____ **Relationship**_____ **Phone**_____

Address_____

Presenting Problem (nature and history)

MENTAL HEALTH PLAN ASSESSMENT FORM

Risk Assessment

Current harm to self-risk ☐ N/A ☐ Ideation ☐ Intent ☐ Plan ☐ Means Describe:

History of:

Current harm to others risk ☐ N/A ☐ Ideation ☐ Intent ☐ Plan ☐ Means: Describe:

History of:

Describe: (note if a particular person is at risk)

Assaultive/Combative ☐ No ☐ Yes If yes, describe:

At risk of abuse or victimization ☐ No ☐ Yes Describe:

Have all mandated reporting requirements been met?
☐ Yes, by this Provider Yes, by :
☐ No (Explain)
Other:

Client Strengths

MENTAL HEALTH PLAN ASSESSMENT FORM

Client Name: _____

Culture/Diversity: Assess unique aspects of the client, including culture, background, and sexual orientation, that are important for understanding and engaging the client and for care planning.

Preferred language for receiving our services: _____

Culture client most identifies with: _____

Problems client has had because his/her cultural background: ☐ None

Sexual orientation issues: ☐ None

Support/ involvement of family in client's life: ☐

Desire of client involvement of family or others in treatment: ☐ Desires

Psychiatric History (Medication(s) and dosage (current))

Medication(s) (past):

History of Mental Illness in Family ☐ No ☐ Yes If yes, describe:

Prior Hospitalization(s) ☐ No ☐ Yes If yes, when, where

Prior Outpatient Treatment ☐ No ☐ Yes If yes, when and with whom:

MENTAL HEALTH PLAN ASSESSMENT FORM

Client Name: _____

Medical History Health Problems (current) ☐ No ☐ Yes If yes, describe:

Height: _____ Weight : _____ (Mandatory if client is a MINOR)

Sleep Disturbance ☐ No ☐ Yes If yes, describe:

Appetite ☐ Too Little ☐ Too Much Weight gain: _____ lbs. Weight Loss: _____ lbs.

Disability ☐ Developmental ☐ Physical ☐ Cognitive Describe:

Allergies ☐ No ☐ Yes Describe:

Adverse response to medications ☐ No ☐ Yes If yes, describe:

MENTAL HEALTH PLAN ASSESSMENT FORM

Substance Use/ Abuse				
	No Use	Frequency	Amount	Last Use
Nicotine	☐			
Caffeine	☐			
Alcohol	☐			
Marijuana	☐			
Amphetamines	☐			
Hallucinogens	☐			
Cocaine/Crack	☐			
Heroin	☐			
Prescription Meds	☐			
Other:	☐			

Mental Status			
Appearance:	☐ Clean	☐ Well-groomed	☐ Dirty
	☐ Disheveled	☐ Inappropriate clothing	
Orientation:	☐ Person	☐ Place	☐ Time
	☐ Situation	☐ Disoriented	
Speech:	☐ Organized/Clear	☐ Coherent	☐ Rapid
	☐ Slowed	☐ Mumbling	
Thought Process:	☐ Organized	☐ Coherent	☐ Tangential
	☐ Thought Blocking	☐ Flight of Ideas	
	☐ Poor Concentration	☐ Obsessive	
Thought Content:	☐ Normal	☐ Delusional	☐ Grandiose
	☐ Other		
Perceptual Process:	☐ Normal	☐ Auditory hallucinations	
	☐ Visual hallucinations	☐ Other	
Insight:	☐ Good	☐ Average	☐ Poor
	☐ None		
Judgment:	☐ Good	☐ Average	☐ Poor
	☐ None		
Mood:	☐ Normal	☐ Hopeless	☐ Irritable
	☐ Elevated	☐ Labile	☐ Depressed
	☐ Anxious	☐ Sad	☐ Manic
Affect:	☐ Appropriate	☐ Inappropriate	☐ Blunted
	☐ Flat	☐ Tearful	
Memory:	☐ Intact	☐ Immediate Memory Problem	
	☐ Recent Memory Problem	☐ Remote Memory	
Estimated Intellectual Functioning:	☐ Average	☐ Below Average	☐ Above Average
Cognitive Deficits:	☐ None	☐ Cognitive Deficits Present	
	☐ Concentration Deficits Present		

MENTAL HEALTH PLAN ASSESSMENT FORM

Client Name: _____

Impairments requiring Mental Health Treatment:

Dysfunction Rating ☐ None ☐ Mild ☐ Moderate ☐ Severe

Describe how symptoms impair functioning:

Employment/ Education:	**Occupation:**	
☐ Competitive job market, 35 hours or more per week	☐ Rehabilitative work, less than 20 hours per week.	☐ Volunteer Work
☐ Competitive job market, less than 20 hours per week	☐ School, full time	☐ Retired
☐ Full-time homemaking responsibility	☐ Job training, full time	☐ Resident/Inmate
☐ Rehabilitative work, 35 hours or more per week	☐ Part-time school/job training	☐ Unknown
☐ Not in Labor force	☐ Highest Grade completed_____	

Medical Necessity

* ☐ Qualifying mental health diagnosis
☐ Qualifying impairment is an important area of life functioning
☐ Probability of a significant deterioration in an important area of life functioning
☐ (Children only) Probability that child will not progress developmentally as individually appropriate
☐ EPSDT – Qualified
* ☐ Planned interventions will address impairment conditions
* ☐ Client is reasonably expected to benefit and improve with respect to impairments
* ☐ Condition would not be responsive to physical health care-based treatment

*All asterisked items must be present, plus 1 more and must be supported by documentation in record

Other Providers/ Agencies client is involved with:

Signature of Provider_____ Date_____

Printed Name_____