

Milwaukee County  
Department of Health and Human Services  
Disability Services Division  
**Wraparound Transitional Pre-Screen for Youth Turning 18**

To determine if a young adult may need services from **Disability Resource Center of Milwaukee County** because she/he has a developmental or physical disability, please complete this form below. Do not send form until child turns 17.5 (assessment will occur 3 months prior to the young adult's 18<sup>th</sup> birth date)

Young Adult's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SSI Amount: \$ \_\_\_\_\_ Other funding: \_\_\_\_\_

Current Placement: (Check One) Foster Care \_\_\_ Group Home \_\_\_ Institution \_\_\_  
Date placed in current situation: \_\_\_\_\_  
Name of current residential facility or provider: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Current School: \_\_\_\_\_ Type of Program: \_\_\_\_\_  
Current Grade Level: \_\_\_\_\_ Name of Teacher: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you feel the young adult will require a guardian when she/he turns 18? Yes \_\_\_ No \_\_\_  
Name of Proposed guardian: \_\_\_\_\_ Phone \_\_\_\_\_  
What is the status of the guardianship process: \_\_\_\_\_

Name of Significant Others/Relatives (support or emergency contracts):  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation to client \_\_\_\_\_  
Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relation to client \_\_\_\_\_

Major Presenting Problems/Additional Comments:

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**To refer a young adult to Disability Resource Center there must be attached documentation of the disability. A recent psychological evaluation must be included. Please ensure that any psychological testing and assessments performed yields an adult diagnosis. Check all that apply:**

\_\_\_\_\_ Cerebral Palsy \_\_\_\_\_ Autism \_\_\_\_\_ Brain Injury  
\_\_\_\_\_ Cognitive Delay (IQ below 70) \_\_\_\_\_ Physical Disability \_\_\_\_\_ Epilepsy

Wraparound Case Manager Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Wraparound (DRC Liaison) Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Send to: **Disability Resource Center of Milwaukee County, Attn: Enrollment Supervisor,  
1220 W. Vliet Street, 3<sup>rd</sup> Floor, Milwaukee, WI. 53205 or Fax to: (414) 289-8570** Revised 7/5/13