**COORDINATED CARE INITIAL REFERRAL FORM**

|  |  |  |
| --- | --- | --- |
| Date of Referral: |  | Release of Information signed? Please complete for follow up with referring agency/individual.  Yes \_\_\_\_ No \_\_\_\_\_ |
|  | |  |
| Name of Youth: | | Date of Birth: |
| Address: | | Age: |
| City, State, Zip: | | Gender:  Pronouns: |
| Phone #: | | Email: |
|  | |  |
| Mother’s Name: | | Father’s Name: |
| Address: | | Address: |
| City, State, Zip: | | City, State, Zip: |
| Phone #: | | Phone #: |
| Email: | | Email: |
|  | |  |
| Legal Guardian: | | Phone #: |
| Address: | | City, State, Zip: |
| Email: | |  |

**Family**

|  |  |  |  |
| --- | --- | --- | --- |
| Name | Age (if Youth) | | Relationship to youth? |
|  |  | |  |
|  |  | |  |
|  |  | |  |
|  |  | |  |
|  |  | |  |
|  |  | |  |
|  |  | |  |
| Person Making Referral: | | Phone #: | |
| Referral Agency: | | Email: | |

|  |
| --- |
| Please give a detailed description of the behaviors and concerns that prompted this referral (criminal history, school issues, family dynamics, current living situation, etc.):  Programs that the youth/family have participated in or are currently participating in: |

**SOCWI**

**Screening Checklist**

**Union County, Oregon**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Youth’s Name:** | **Yes** | **No** | **Comments** |
| **Must Meet the Following Criteria:** |  |  |  |
| **Youth and family are engaged in Mental Health services through Center for Human Development** (Main Office, Union-La Grande-Elgin SBHC/SBMH, Elgin Family Clinic)- **A Mental Health Assessment and Treatment Plan must be current.** |  |  |  |
| **Must Meet the Following Criteria:** |  |  |  |
| Youth is at risk of placement outside the home community due to mental health/behavioral challenges: Youth is at risk of residential treatment, is currently in residential treatment, or has regressed upon return from a treatment facility. |  |  |  |
| **Additional Supporting Criteria (check all that apply)** |  |  |  |
| Youth has a family\* |  |  |  |
| Youth is involved with at least 1 child serving systems/agencies, e.g. Child Welfare, Juvenile Justice, CARE coordinators, Schools, Developmental Disabilities, etc. |  |  |  |
| Youth is displaying emotional and behavioral issues that result in social concerns |  |  |  |
| School disruption due to suspension and/or expulsion |  |  |  |
| Permanency status in question (disrupting adoption, pre-finalized adoptions, new relative placements, etc.) |  |  |  |
| Elevating risk of harm to self or others including sexualized behaviors, fire setting etc. |  |  |  |
| Does the youth have Oregon Health Plan (EOCCO/GOBHI/Open Card) |  |  |  |
| Youth has medical condition/s that may be impacting/ contributing to behavioral challenges. |  |  |  |

\*”Family” means the biological or legal parents, siblings, other relatives, foster parents, legal guardians, spouse, domestic partner, caregivers and other primary relations to the individual whether by blood, adoption, legal or social relationships. Family also means any natural, formal or informal support persons identified as important by the individual.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referral Outcome**

|  |  |  |
| --- | --- | --- |
| **Youth’s Name:** |  |  |
| **Family is screened into Wrap:** | | |
| **Assigned to the following Wrap Care Coordinator:** |  | Tylee Clark |
|  | Danielle Stolk |
| **Family is Not screened into Wrap:** | | |
| Engagement was attempted but was not successful. Describe: | | |
| Family declined to participate in services. Explain: | | |
| Family is screened into alternate services.  Explain: |  | Outpatient Mental Health |
|  | ISA/ Care Coordination: |
|  | Other: |

\* If ROI is in place, give copy of completed Outcome to referring agency/individual.