# Systems of Care Wraparound Referral

### CONSENT FOR CARE COORDINATION SCREENING & SERVICES

I understand that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has been referred to Wraparound and this will include a review of records regarding them.

The Wraparound Review Committee will meet to determine if they meet criteria for the Wraparound programs. The review committee is made up of community partners that may include Mental Health, Juvenile Department, Child Welfare, School partners, Developmental Disabilities, Oregon Family Support Partners, Youth Move Oregon, PSU, and potentially other invested community partners.

The team will review the youth and their family’s strengths, needs, current supports and agencies involvement and determine if they meet criteria for Wraparound. After the committee has met, the assigned Wraparound Coordinator will notify you if they have been accepted into Wraparound along with suggested recommendations the committee has brainstormed.

Potential information to be reviewed may include physical and behavioral health records, school records, and juvenile court records. I understand that all information will be kept private unless I sign a Release of Information directing Community Counseling Solutions what information they can share and with whom. Health information is protected by State and Federal law as well as Health and Human Service Policy.

**I understand that participation in the screening process is voluntary and by signing below I give my permission to participate.**

|  |  |  |  |
| --- | --- | --- | --- |
| Youth Signature | |  | Date |
| Parent/Guardian Signature | Relationship |  | Date |
| Parent/Guardian Signature | Relationship |  | Date |

**Systems of Care Wraparound Referral**

**UMATILLA COUNTY WRAPAROUND**

**REFERRAL FOR ELIGIBILITY DETERMINATION (Submit to crystal.ross@ccsemail.org)**

All requested information MUST be provided. Incomplete forms will be returned to the referrer.

**YOUTH INFORMATION**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Youth Name: |  | | | | | | | | | | Date of Birth: | | | | | |  | | | | | | | | | | | | Age: |  |
| Oregon Health Plan? Yes ☐ No ☐ | | | | | | | | | | | | | | | | | | | If yes, Prime ID: | | | | | | | | |  | | |
| Does youth have private insurance in addition to OHP? Yes ☐ No ☐ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If yes, private insurance carrier: | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | |
| Please circle the child and family serving systems this youth is involved in | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DHS Juvenile Justice Developmental Disabilities Mental Health Medical CARE CASA | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Drug & Alcohol IEP/504 (Special Education) Other : | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | |
| Referred by: | | | | |  | | | | | | | | | Relationship: | | | | | | | | | |  | | | | | | |
| Phone: | |  | | | | | | | | | | | | | | | | Fax: | | | | | |  | | | | | | |
| Current Mental Health Provider: | | | | | | | | | |  | | | | | | | | | | | Phone: | | | | | |  | | | |
| Primary Care Provider: | | | | | | | | |  | | | | | | | | | | Phone: | | | | | | |  | | | | |
| Current School: | | | | | | |  | | | | | | CANS included Yes ☐ No ☐ N/A ☐ | | | | | | | | | | | | | | | | | |
| Legal Guardian: | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | |
| Name(s): | | | | | | | | | | | | | | | Relationship: | | | | | | | |  | | | | | | | |
| Address: | | | | Phone: | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Email address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Emergency Contact: | | | | | | | |  | | | | | | | | Phone: | | | | | | |  | | | | | | | |
| Current Placement Information, if different than above: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name(s): | | |  | | | | | | | | | | Relationship: | | | | | | |  | | | | | | | | | | |
| Address: | | |  | | | | | | | | | | | | | | | | | | | | | |  | | | | | |
| Email address: | | | | | | | | | | | | | | | | | | Phone: | | | |  | | | | | | | | |
| Biological Family information, if different than above: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name(s): | | |  | | | | | | | | | Relationship: | | | | | | | | |  | | | | | | | | | |
| Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Email address: | | | | | |  | | | | | | | | | | | Phone: | | | | | | | | |  | | | | |

**Systems of Care Wraparound Referral**

Summary of reason for referring this youth to Wraparound

*What has been tried already? What worked and what didn’t? What other systems is the youth/family involved in?*

Strengths of the Youth & Family

Needs of the Youth & Family

*Specific cultural/linguistic needs (cultural connections and resources, gender specific, hearing/vision, and interpreters)*

How will the Youth and Family Benefit from Wraparound?

**Systems of Care Wraparound Referral**

|  |  |  |
| --- | --- | --- |
| Umatilla County Wraparound Eligibility Criteria and Referral Checklist  **Name: Age: Date of Referral:** | | |
| **All referrals to Wraparound must meet the following 5 criteria:** | **Criteria Met:** | Additional information:  **\*please explain each checked item** |
| Enrolled in EOCCO (Medicaid Eligible-OHP Primary) | **☐** |  |
| Multi-system involvement (for example: MH, DHS, JJ, DD, CARE, Medical, IEP/504, etc.) | **☐** |  |
| Youth is under 18 years of age | **☐** |  |
| Care Coordination needs cannot be met by the other systems or lower levels of care  **(please explain)** | **☐** |  |
| Family/Guardian **interested and willing** to engage in Wraparound process | **☐** |  |
| **Additional Prioritized Criteria: Must meet 2** |  |  |
| Elevating risk of harm to self or others including sexualized behaviors, fire setting | **☐** |  |
| Significant risk of losing current placement and/or multiple moves within the system | **☐** |  |
| School disruption due to suspension and/or expulsion | **☐** |  |
| Permanency status in question (disrupting adoption, pre-finalized adoptions, new relative placements, etc.) | **☐** |  |
| Youth is displaying emotional and behavioral issues and there are social concerns | **☐** |  |
| Proactive planning for youth who will be transitioning to reside in Umatilla County | **☐** |  |

\*\*No more than one youth of the same household referred in one month. Wraparound must be conducted for at least three months\*\* before a Wraparound referral of a sibling is completed.

**Automatic Acceptance if youth is currently placed in one of the following programs and Family interested in engaging in the wraparound process:**

* Secure Adolescent Inpatient Program (SAIP) or Secure Children’s Inpatient Program (SCIP),
* Psychiatric Residential Treatment Services (PRTS),
* Commercially Sexually Exploited Children’s residential program (CSEC)

*Procedure: Within 24 hours of Wraparound Review Committee convening the WCC to make contact with the family will communicate the committee recommendations and determination for 1) acceptance into Wraparound, 2) pending acceptance into Wraparound or 3) no acceptance into Wraparound to the referent. If a youth is accepted into Wraparound a WCC will contact the family within three days. If the youth is pending acceptance to Wraparound the referent will convey recommendations to the youth and family as well as ensure follow-up on recommendations. GOBHI staff will manage a prioritized Pending Wraparound list based on the above criteria and communicate to the referent the identified youth’s status on the list monthly until youth is enrolled into Wraparound or needs have been met by other community-based resources.*