WALLOWA VALLEY
CENTER for WELLNESS

WRAPAROUND IIBHT DD EASA REFERRAL FORM (please circle)

Youth Name _____ Date of Birth:_____

Age: _____ Date of Wraparound referral _____

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
Drug & Alcohol IEP/504 (Special Education) Other _____

Referred by: _____ Relationship: _____

Phone: _____ Fax: _____

Current Mental Health Provider:_____ Phone: _____

Primary Care Provider: _____

Current School: _____

Legal Guardian:
Name(s):_____ Relationship: _____
Address: _____
Email address: _____
Emergency Contact: _____Phone: _____

Current Placement Information, if different than above or SAME
Name(s):_____ Relationship: _____
Address: _____
Email address: _____
Emergency Contact: _____ Phone: _____

Biological Family information, if different than above or SAME
Name(s):_____ Relationship: _____
Address: _____
Email address: _____
Phone: _____

What do you think of as your primary racial or ethnic group? _____
What language or languages do you use at home _____
In what language do you want us to communicate with you_____
Deaf interpreter for deaf/blind and with additional barriers ? _____

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All referrals to Wraparound must meet the following 5 criteria:	**Criteria Met:**	**Notes:**
Enrolled in EOCCO (Medicaid Eligible-OHP Primary)		
Multi-system involvement (MH, DHS, JJ, DD, Medical, IEP with ED/out of mainstream placement)		
Youth is under 21 years of age		
Care Coordination needs cannot be met by the other systems		
Family/guardian interested and willing to engage in Wraparound process		
Additional Prioritized Criteria:		
Youth is at risk of losing stable housing or is homeless		
Multiple Hospitalizations		
Proactive planning for youth who will be transitioning to reside in Columbia County		
Multiple resources within the child serving system have been explored & the level of service need is outside "traditional services and supports"		
Dual Diagnosis of Mental Health and Developmental/ Intellectual Developmental Disabilities		
Current natural supports are unable to provide amount of support needed		

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, Program Manager/Care Coordinator 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 be assigned and 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. Wallowa Valley Center for Wellness (WVCW) staff will manage a prioritized Pending Wraparound list based on the above criteria and communicate to the referent the referred youth's status on the waitlist monthly until youth is enrolled into Wraparound or needs have been met by other community based resources.

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Summary of reason for referring this youth to the Wraparound

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?

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CONSENT FOR CARE COORDINATION SCREENING & SERVICES

I understand that _____has been referred to Wallowa Valley Center for Wellness for Wraparound services and this referral may include a review of records regarding them.

The Wraparound Review Committee meets regularly to determine if a referred youth meets criteria for the Wraparound program. The review committee is made up of community partners that include health care providers, juvenile department, child welfare, school staff, Developmental Disabilities, Oregon Family Support Partners, Youth Move Oregon and Greater Oregon Behavioral Health Initiative (GOBHI).

Youth caregivers are always encouraged to attend ! Their participation is greatly appreciated and helps the referral committee get a clear picture of what the youth and family need to feel supported and successful

The team will review the family's strengths, needs, current supports, agency involvement to determine if they meet criteria for Wraparound. After the committee has met, the Wraparound Care Coordinator will notify you if they have been accepted into Wraparound along with suggested recommendations from the committee.

Potential information that may need to be reviewed may include physical and behavioral health records, school records and juvenile court records. 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 the providers and employees of the agencies listed above to review necessary records. I understand that all information will be kept within the committee and kept private except for the purposes of assessing a referral.

_____ _____

Youth **Date**

_____ _____ _____

Legal Guardian **Relationship** **Date**

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AUTHORIZATION TO USE AND DISCLOSE INFORMATION

PURPOSE: For the purposes of determining eligibility and providing mental health services and care coordination, I, _____, legal guardian of _____,

on this date _____, authorize WVCW and GOBHI to:

( ) Release Information to: ( ) Obtain Information from: ( ) Exchange Information with all the below.

Name/Agency	Address	Phone
Wallowa Valley Center for Wellness	606 Medical Parkway, Enterprise, OR 97828	(541)426-4524
All schools served by the Wallowa County ESD	107 SW First St, Enterprise OR 97828 (Educational School District)	(541) 426-7600
Winding Waters Clinics	603 Medical Parkway Enterprise OR 97828	(541) 426-4502
Wallowa Memorial Hospital	601 Medical Parkway Enterprise OR 97828	(541) 426- 3111
Youth Services of Wallowa Co.	104 W Greenwood St, Enterprise OR 97828	(541) 426-9114
Developmental Disabilities of OR through WVCW	606 Medical Parkway, Enterprise, OR 97828	(541)426-4524
Oregon Dept of Human Services Local office:	500 Summer St NE, Salem OR 97301 104 Litch St, Enterprise OR 97828	(503) 945-5600 (541) 426-4558

Family or Friends?

INFORMATION: The information that is subject to this authorization pertains to the youth for whom the guardian is seeking services, and includes the following:

( ) Mental Health treatment (including assessments, progress notes, and other clinical records)
( ) Alcohol and Substance abuse treatment (including assessments/clinical records, test results)
( ) Medical (including hospitalization and treatment)
( ) Juvenile Dept records
( ) Educational Reports (including: Special Education Eligibility/IEP/School reports)
( ) Family History
( ) Other: _____.

TERM: This authorization will remain in effect from the date of this authorization until the end of services

( ) OR until the following event occurs: _____
( ) OR until client revokes authorization on this date (describe which ones)_____

Legal Guardian understands that they may refuse to sign or may revoke any part of this authorization for any reason at any time. The revocation must be communicated to the care coordinator or youth partner or family partner before it becomes binding. Refusal to sign will not affect ability to obtain treatment or eligibility for services. I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my information. I hereby, knowingly and voluntarily, authorize WVCW (Wallowa Valley Center for Wellness) & GOBHI (Greater Oregon Mental Health Initiative) to use or disclose information in the manner described above.

_____

Signature of Legal Guardian Date

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Consent for Transportation

I, _____, _____
Parent/Guardian Name **Relationship to youth client**

Give consent to the Wraparound team members or colleagues to transport

_____
Youth Name (s)

to and from activities as needed. Transportation will be provided in Wallowa Valley Center for Wellness vehicles.

I authorize and consent for Wallowa Valley Center for Wellness to send and receive youth information to emergency personnel in the case that it is needed or warranted, while transporting the above named youth or during Youth and Family Program activities.

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used and/or disclosed under this authorization.

My consent may be revoked at any time; the only exception is when the action has already occurred as instructed in the consent.

This consent will expire at the end of services. I understand that if my information is released to an entity not covered by federal privacy regulation it may be redisclosed. A copy of this form shall have the same validity as the original.

_____ _____
Parent/ Legal Guardian Signature **Date**

_____ _____
Youth Signature **Date**

_____ _____
Witness Signature **Date**

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HIPPA

By signing below, I consent to the use and disclose of Health Information about me in order that the WVCW and its employees and contractors may provide treatment to me, obtain payment (for the treatment) from my third party payors (e.g. the Oregon Medicaid program or my Health Maintenance Organization or HMO) and carry out their health care operations. I specifically authorize their use and disclosure of my healthcare information about treatment of mental illness, HIV/AIDS test results and alcohol and drug abuse treatment program services (if any) for such treatment, payment and healthcare operations purposes. I understand that this consent to release information expires upon completion of services.

I may revoke this consent prior to that time, except to the extent to which WVCW has taken action in reliance upon this consent. However, I also understand that no revocation of this consent is valid with respect to inspection of records necessary to validate expenditures on behalf of governmental entities.

Initial that this information was received _____ Date _____

Client Name: _____

Client (or personal representative) signature:

_____ Date _____

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TEXT OPT IN AND CONSENT FORM

Wallowa Valley Center for Wellness utilizes a text messaging platform for communicating with our clients regarding healthcare information, appointment confirmations, and scheduling. By signing this consent, you are acknowledging that Wallowa Valley Center for Wellness sends text messages for the purpose listed above only if you opted- in to receive them.

You are also acknowledging that text messages sent to an employee of Wallowa Valley Center for Wellness are not guaranteed a response.

Crisis support is accessed by calling our **Crisis Line at 541-398-1175**

Therapy contact is made via appointment by calling our front office at 541-426-4524.

You can opt-out from receiving these text messages at any time by informing our Wraparound team or front office staff that you would no longer like to receive text message notifications.

Wallowa Valley Center for Wellness will not cover the cost your telephone company may charge to receive text messages. Standard text messaging rates apply.

Occasionally, text messages can get lost or intercepted before they get to your phone. Therefore, Wallowa Valley Center for Wellness cannot guarantee that you will receive the messages.

Wallowa Valley Center for Wellness strongly recommends that you protect your phone with a password to prevent others from reading your text messages.

It is important to inform us if your cell phone number changes to ensure these messages stay private and secure.

By including my cell phone number below and my signature, I agree to receive text messages from Wallowa Valley Center for Wellness for healthcare information, appointment confirmations, and scheduling.

I understand that text messages will only be sent to me when other attempts to contact have been made and have failed UNLESS texting is my preferred form of contact. In that case:

I, _____ HAVE SPECIFIED HERE THAT TEXT MESSAGES ARE MY PRIMARY AND PREFERRED METHOD OF COMMUNICATION

I understand that this consent form expires when I am no longer seeking services. I must complete a new consent form in order to continue this service if it expires.

Cell phone number (s): _____

Relationship (self, other): _____

Signature: _____ Date: _____