# C:\Users\melissal\Desktop\gobhi_logo_2011-182pxwide.gif Systems of Care Wraparound Referral

**WALLOWA COUNTY WRAPAROUND**

**REFERRAL FOR ELIGIBILITY DETERMINATION**

**YOUTH INFORMATION**

|  |
| --- |
| Client 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  Drug & Alcohol IEP/504 (Special Education) Other ­­­­­­­­­­­­­­­­­­­ ­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current Mental Health Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Primary Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Last CANS Assessment: \_\_\_\_\_\_\_\_\_  Current School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CANS included Yes No N/A  Legal Guardian:  Name(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Current Placement Information, if different than above:  Name(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Biological Family information, if different than above:  Name(s):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |
| --- | --- | --- |
| **Wallowa County Wraparound Eligibility Criteria and Referral Checklist**  **Name: Age: Date of Referral:** | | |
| **All referrals to Wraparound must meet the following 5 criteria:** | **Criteria Met:** | **Notes:** |
| Enrolled in CPCCO (Medicaid Eligible-OHP Primary) |  |  |
| Multi-system involvement (MH, DHS, JJ, DD, Medical, IEP with ED/out of mainstream placement) |  |  |
| Youth is under 18 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 |  |  |

\*\*No more than one youth of the same family referred in a 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, Program Manager, Adam Peterson 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. 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 waitlist monthly until youth is enrolled into Wraparound or needs have been met by other community based resources.*

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?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### 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 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 their 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 Care 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 GOBHI 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 Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Legal Guardian Relationship Date**

**GREATER OREGON BEHAVIORAL HEALTH (GOBHI)**

**AUTHORIZATION TO USE AND DISCLOSE INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Authorize GOBHI to:

*Legal Guardian Youth*

( ) Release Information to: ( ) Obtain Information from: ( ) Exchange Information with:

|  |  |  |
| --- | --- | --- |
| Name/Agency | Address | Phone/Fax |
| Wallowa Valley Center for Wellness | 207 SW 1st Street, Enterprise, OR 97828 | (541)426-4524 |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

PURPOSE: For the purpose of Determination/review of eligibility for Mental Health Services and Care Coordination.

INFORMATION: The information that is subject to this authorization pertains to myself and includes the following:

( ) Mental Health treatment (including assessments, progress notes, and other clinical records)

( ) Alcohol and Substance abuse treatment (including assessments and other clinical records, test results)

( ) Medical (including hospitalization and treatment)

( ) Psychological/Psychiatric Evaluation 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 \_\_\_\_\_\_\_\_\_\_ but not to exceed one year from today’s date.

( ) Until the following event occurs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason. My refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits. 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 GOBHI to use or disclose information in the manner described above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature of Legal Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Signature of Youth Date

Signature of Witness Date

Greater Oregon Behavioral Health Inc. (GOBHI)

**Consent for Transportation**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give consent for

Parent/Guardian Name Relationship to Client

the Wraparound Care Coordinators to transport, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

Youth Name

to and from Youth and Family Program activities as needed. Transportation will be provided in Wraparound Care Coordinator’s personal vehicles.

I authorize and consent for GOBHI 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 one year after the date of signature. I understand that if my information is released to an entity not covered by federal privacy regualtion 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