Date of Referral: _____

# Systems of Care Wraparound Referral

## COLUMBIA COUNTY WRAPAROUND

### REFERRAL FOR ELIGIBILITY DETERMINATION

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

**Please submit forms to jamie.hamsa@gobhi.net**

**YOUTH INFORMATION**

Youth Name: _____ Date of Birth:_____ Age: _____ Pronouns: _____

Preferred Name:_____ Previously been in Wraparound? Yes ☐ No ☐

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: _____ Phone: _____
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: _____

Date of Referral: _____

| Columbia County Wraparound Eligibility Criteria and Referral Checklist | | |
|---|---|---|
| **All referrals to Wraparound must meet the following 5 criteria:** | **Criteria Met:** | **How Criteria Meets:** |
| 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 | | |
| Transitioning from another county's Wraparound program | | |

**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, Jamie Hamsa 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 pending list monthly until youth is enrolled into Wraparound or needs have been met by other community based resources.*

Date of Referral: _____

## Strengths of the Youth & Family: Include Natural Supports

## Reason for referring this youth to the Wraparound? If re-referral, please explain

*(Include: Needs of Youth and Family. Specific cultural/linguistic needs (cultural connections and resources, gender specific, hearing/vision, and interpreters))*

## How will the Youth and Family benefit from Wraparound?

Date of 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 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**

Date of Referral: _____

**GREATER OREGON BEHAVIORAL HEALTH, INC.**

**AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION**

**SECTION A: The name of the person, or class of persons, who may authorize the requested use or disclosure.**

I, _____or my authorized representative, authorize _____ to disclosure my protected health information as described in Section B below. I understand that:

1. My treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this use or disclosure.
1. I am entitled to a copy of this authorization.

**SECTION B: Entities Authorized to Receive or Use the Individual's Protected Health Information:**

Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations) to whom you are authorizing us to disclose or who may use the protected health information described above:

School District: _____ _____

Foster Parent/other Individual: _____ _____

Police/Sheriff Departments: _____ _____

_____ _____

_____ _____

_____ _____

_____ _____

**GOBHI only releases the Wraparound Crisis and Safety Plan to Police/Sheriff Departments**

**SECTION C: Protected Health Information to Be Used and/or Disclosed:**

Specifically and meaningfully describe the protected health information you are authorizing to be used or disclosed.

☐ All Records ☐ _____

**SECTION D: Purpose of the Use or Disclosure:**

Describe the reason for the use or disclosure of this information.

The statement "at the request of the individual" is a sufficient description of the purpose when you initiate the authorization and do not, or elect not to, provide a statement of the purpose.

☐ Wraparound Care Coordination ☐ _____

**SECTION E: Expiration and Revocation.**

This authorization will expire (complete one):

☐ On _____/_____/_____ (one year or less)

☐ On occurrence of the following event (which must relate to you or to the purpose of the disclosure being authorized):

_____

Date of Referral: _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Compliance Office – Privacy Officer
Telephone: 541-298-2101 Fax: 541-298-7996
E-mail: privacy@gobhi.net
Address: 401 E. 3rd Street, Suite 101 The Dalles, OR 97058

**SECTION F: Signature.**

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____ Date: _____

*If this authorization is signed by a personal representative on behalf of the individual, complete the following:*

Personal Representative's Name: _____

Relationship to Individual: _____

Description of Authority to Act for the Individual: _____

**SECTION G: Prohibition of Re-disclosure – To be provided to the Recipient of the authorization**

**NOTICE PROHIBITING REDISCLOSURE OF PROTECTED HEALTH INFORMATION**

You are prohibited from making any further disclosure of this information unless expressly permitted to do so by the written consent of the person or his/her personal representative who is authorizing its use or disclosure. (ORS 179.505(14)

Date of Referral: _____

# 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 understand that GOBHI is providing transportation for free of charge for my child and other clients, which at times require picking up multiple youth for group therapeutic activities. I understand that my child's address at times may be disclosed to other by nature of carpooling, but staff will not provide the information verbally or in written form.

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 regulation it may be disclosed. A copy of this form shall have the same validity as the original.

_____ _____
Parent/ Legal Guardian Signature Date

_____ _____
Youth Signature Date

_____ _____
Witness Signature Date

Date of Referral: _____