# Wraparound Referral – Umatilla County

# \*Please complete all pages and then email to: wraparound@ccsemail.org.

**Please have the youth and/or their family complete this section:**

|  |  |  |
| --- | --- | --- |
| I understand that |  | has been referred to the following program: |

[ ]  Wraparound

[ ]  Intensive Care Coordination (ICC)

A Wraparound Review Committee will meet to review this referral. They will discuss the youth and the family’s strengths and needs. You are welcome to be a part of this meeting. A Wraparound Care Coordinator will call you after the Committee meets. They will share the committee’s decision. They will also share any recommendations the committee may make.

*I understand that Wraparound is voluntary, and I am interested in participating.*

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

Reviewer use only:

|  |
| --- |
| **Date Referral was Reviewed by Committee:** **Outcome of referral:** |

**The youth will automatically be accepted if they are currently placed in one of the following programs *and* the family is willing to engage 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 the Wraparound Review Committee convening, the Wraparound Care Coordinator (WCC) will contact the family and share the committee’s determination and recommendations. If a youth is accepted into Wraparound, a WCC will contact the family within three days.*

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| **Umatilla County Wraparound Eligibility Checklist** |
| **Name: Age: Date of Referral:** |
| **All Wraparound referrals must meet the following 6 criteria:** |
| Enrolled in EOCCO (Medicaid Eligible-OHP Primary)  | [ ]  |  |
| Multi-system involvement and these systems are not able to meet needs effectively (for example: MH, DHS, JJ, DD, CARE, Medical, IEP/504/School, etc.) | [ ]  | Notes/Explanation:  |
| Youth is 21 years of age or younger | [ ]  | Notes/Explanation: |
| Care Coordination needs cannot be met by the other systems or lower levels of care  **(please explain)** | [ ]  | Notes/Explanation: |
| The Family/Guardian **is interested and willing** to engage in the Wraparound process | [ ]  | Notes/Explanation: |
| Has the youth had a mental health assessment within the past year, or do they have one scheduled within the next 60 days? | [ ]  | Notes/Explanation: |
| **Additional Criteria: Must meet at least 2** |
| Elevating risk of harm to self or others including sexualized behaviors, fire setting **(please explain)** | [ ]  | Notes/Explanation: |
| Significant risk of losing current placement and/or multiple moves within the system **(please explain)** | [ ]  | Notes/Explanation: |
| School disruption due to suspension and/or expulsion**(please explain)** | [ ]  | Notes/Explanation: |
| Permanency status in question (disrupting adoption, pre-finalized adoptions, new relative placements, etc.) **(please explain)** | [ ]  | Notes/Explanation: |
| Youth is displaying emotional and behavioral issues and there are social concerns **(please explain)** | [ ]  | Notes/Explanation: |
| Proactive planning for youth who will be transitioning to reside in Umatilla County **(please explain)** | [ ]  | Notes/Explanation: |

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| --- | --- | --- | --- | --- | --- |
| Youth’s Name: |  | Date of Birth:  |  | Age: |  |

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| Oregon Health Plan? | Yes [ ]  | No [ ]  | OHP Member ID: |  |

Does the youth have private insurance in addition to OHP? Yes [ ]  No [ ]

|  |  |
| --- | --- |
| If yes, private insurance carrier: |  |

Please mark the systems this youth and their family are involved in:

1. Mental Health [ ]
2. Juvenile Justice Probation Officer / OYA Detention [ ]
3. DHS Child Welfare Permanency Worker Assigned [ ]
4. Intellectual Developmental Disabilities Services Coordinator Assigned [ ]
5. Has an IEP/504 or education/school behavioral concerns [ ]

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| --- | --- | --- |
| F. Other | [ ]  |  |

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| --- | --- | --- | --- |
| **Referred by:** |  | Relationship: |  |
| Phone: |  | E-mail: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Current School:** |  | Guidance Counselor/Point of Contact: |  |

|  |  |
| --- | --- |
| **Current Mental Health Provider:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone: |  | E-mail: |  |

**Current Healthcare Provider/clinic:**

|  |  |  |
| --- | --- | --- |
|  | Phone: |  |

**Family Information:**

|  |  |
| --- | --- |
| Parents: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone: |  | Address: |  |

|  |  |
| --- | --- |
| Current Placement: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone: |  | Address: |  |

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| **What has been tried already? What worked and what didn’t?** |
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| **What are the youth and family good at (strengths)?** |
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| **What specific needs do the youth & family have? Include cultural and language needs.** |
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| --- |
| **How will Wraparound help the youth and family?** |
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| --- | --- | --- |
| **Would the youth like to work with a Youth Partner?** | **Yes**  [ ]  | **No**  [ ]  |
| **Would the family like to work with a Family Partner?** | **Yes**  [ ]  | **No**  [ ]  |