Wraparound Referral Form

Hood River, Sherman, and Wasco Counties

Referral for eligibility determination – Please fill out form completely

Youth Information

Youth Name:		Date of Birth:	
Youth's Legal Name: (if different than above)		Age:	
Pronouns:		Primary Language:	
Telephone:			
Oregon Health Plan: ☐ YES ☐ NO	If yes, Prime ID #:	Other Health Insurance: ☐ YES ☐ NO	If yes, Insurance Carrier:

Please check the child and family serving systems this youth is currently involved in: (check all that apply)

☐ Mental Health ☐ DHS ☐ Juvenile Justice ☐ Intellectual/Developmental Disabilities ☐ Medical

☐ Substance Abuse/Addictions Counseling ☐ Inpatient Treatment Programs (SAIP/SCIP/PRTS/CSEC) ☐ IEP/504

☐ Other:

Referred by:		Relationship:	
Phone:		Email:	
Mental Health Agency:		Therapist:	
Primary Care Provider:		Medication Prescriber:	
Current School:		IEP /504:	☐ Yes ☐ No
		Grade:	
Other Involved Agencies:		Email:	
		Phone:	
Other Involved Agencies:		Email:	
		Phone:	

Legal Guardian / Parent Information

Name(s):		Pronouns:	
Legal Name(s): (if different than above)		Relationship:	
Address:		Telephone:	
Email Address:		Primary Language:	

Current Placement Information, if different than above

Name(s):		Pronouns:	
Legal Name(s): (if different than above)		Relationship:	
Address:		Telephone:	
Email Address:		Primary Language:	

Biological Family Information, if different than above

Name(s):		Pronouns:	
Legal Name(s): (if different than above)		Relationship:	
Address:		Telephone:	
Email Address:		Primary Language:	

Emergency Contact: Phone:

Please submit to Wraparound Care Coordinator Lindsey White (541) 716-4278 LWhite@MCCFL.org
Drop off at either Mid-Columbia Center for Living location or send via secure email

Eligibility Criteria for Wasco, Hood River, and Sherman County Wraparound		
	Criteria met:	Additional information:
All referrals to Wraparound must meet the following 5 criteria:		
Multi-system involvement (MH, DHS, JJ, DD, Medical, IEP/504)	☐	
Youth is under 18 years of age	☐	
Family/guardian and youth are interested and willing to engage in the Wraparound process (Consent form signed)	☐	
Youth has completed a Mental Health Assessment within 1 year of referral acceptance, or agrees to	☐	
Care Coordination needs cannot be met by the other systems	☐	*What has been tried already?*
Additional Prioritized Criteria: Must meet at least 2 of the following criteria		
Youth is at high risk of harm to self or others, and this is disrupting daily life/activities	☐	
Significant risk of losing current home placement due to mental health/behavioral health needs	☐	
Significant risk of losing current school, after school, or daycare placement due to behaviors and/or mental health needs	☐	
Likely, or frequent, admission to inpatient or intensive treatment services	☐	
The family support system is stressed and/or environmental stressors are impacting activities of daily living	☐	
Automatic Acceptance if youth is currently placed in one of the following programs and youth/family is 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)	☐	

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To help us understand the youth and family being referred, please include as much information as possible in the following sections.

Please describe the **strengths** of youth and family:

Please describe the **needs** of youth and family:

Reason for referring this youth to Wraparound and how you think youth and family may benefit from Wraparound:

Cultural considerations:

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CONSENT FOR CARE COORDINATION SCREENING & SERVICES

I understand that _____ (Youth) has been referred to Wraparound and this will include a review of youth's records.

The Wraparound Review Committee will meet to determine if youth meets criteria for the Wraparound process. The review committee is made up of community partners that include the Wraparound team members, Mental Health, Department of Youth Services, Juvenile Justice, Child Welfare, Self-Sufficiency, school partners, Developmental Disabilities, Public Health, Substance Use Treatment, and potentially other invested community partners.

The committee will review the referral, which includes the youth and family's strengths, needs, current supports and multi-system involvement to 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, mental health records, and juvenile court records. I understand that all information will be kept private unless I sign a *Release of Information* directing MCCFL what information can be shared and with whom. Health information is protected by State and Federal law as well as Health and Human Service Policy.

If accepted into Wraparound, a CANS (Child and Adolescent Needs and Strengths summary) assessment will be done by the Wraparound Care Coordinator to help guide the Wraparound process. By signing below I also give permission for this assessment to be completed.

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

_____ _____

Youth (if 14yrs or older) Date

_____ _____

Legal Guardian Date

_____ _____

Interpreter Signature (if applicable) Date

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