



Systems of Care Wraparound Referral

BAKER COUNTY WRAPAROUND REFERRAL FOR ELIGIBILITY DETERMINATION

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

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: _____

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: _____

Baker 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 EOCCO (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: Must meet 2		
Elevating risk of harm to self or others including sexualized behaviors, fire setting		
Youth is displaying emotional and behavioral issues and there are social concerns		
Significant risk of losing current placement and/or multiple moves within the system		
School disruption due to suspension and/or expulsion		
Permanency status in question (disrupting adoption, pre-finalized adoptions, new relative placements, etc.)		
Proactive planning for youth who will be transitioning to reside in Baker County		

****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.

Date of Referral: _____

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?

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: _____