Program Review Committee

Referral Form

Youth Name: _____D.O.B:_____Age:_____

Provider will select which program best fits client:
(If self-referred, please select which program) See page 3 and 4 to enroll your child into:

Wraparound ☐ IIBHT ☐ ICC ☐ EASA ☐ School Based Mental Health ☐

Oregon Health Plan (circle one): Yes No OHP Member ID #:_____

Does the youth have private insurance in addition to OHP (circle one): Yes No
If yes, private insurance carrier:_____

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

A. Mental Health
B. Juvenile Justice Probation Officer/ OYA Detention
C. DHS Child Welfare Permanency Worker Assigned
D. Intellectual Developmental Disabilities Services Coordinator Assigned
E. Has an IEP or 504 Plan

Referred by:_____ Relationship:_____
Phone: _____Email:_____
Fax:_____
Current School: _____ Phone:_____
Current Mental Health Provider: _____
Phone: _____Email:_____
Fax: _____

Youth and Family Information

Biological Parents: _____ Relationship:_____
Phone:_____Address:_____
Current Placement:_____ Relationship:_____
Phone:_____Address:_____
Legal Guardian:_____Relationship:_____
Phone: _____ Address:_____

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Have the youth and family consented to presentation?	Yes	No
Have the youth and family been invited to present?	Yes	No
would the youth like to work with a Youth Partner*	Yes	No
Would the family like to work with a Family Partner7	Yes	No

Describe youth and family strengths:

Describe youth and family's needs:

Cultural Considerations:

_____	_____	_____
Youth Signature (Required if over 14 years)	Printed Name	Date
_____	_____	_____
Legal Guardian Signature	Printed Name	Date
_____	_____	_____
Biological Parent Signature (if youth is in DHS custody)	Printed Name	Date

Programs Criteria:

Wraparound:

is an intensive team-based planning process that follows a series of steps to help children, young adults, and their families accomplish their family vision. This individualized care planning process is a shared commitment amongst professionals, youth, families, and natural supports to the 10 principles of Wraparound to drive the process.

Who is eligible for Wraparound?

1. Medicaid Eligible
2. Multi-system involved (Mental Health, Child Welfare, Juvenile Justice, Developmental Disabilities, Medical, Mental Health needs affecting academic, social, and emotional developmental progress) (SEP/504)
3. 0-17 years of age
4. Identified family/guardian and youth are willing to engage in the Wraparound Process
5. Wraparound is a voluntary process and not a mandatory service.
6. Care Coordination needs cannot be met by other system partners.

Intensive In-Home Behavioral Health Treatment (IIBHT):

is an Oregon Health Plan (OHP) level of care for youth and families who have intensive behavioral health symptoms, multisystem needs, and/or are at risk of placement disruption that will be implemented in 2021.

Who can access these services?

Medicaid-eligible children and youth through age 20 (under age 21) who display Intensive behavioral health needs, which shall include:

1. Multiple behavioral health diagnoses; and
2. Impact on multiple life domains (school, home, community) effected as identified on the mental health assessment; and

8. Significant safety risks or concerns; or

4. Are at risk of out-of-home treatment or placement; or
5. Are transitioning home from an out-of-home treatment or placement.

Intensive Care Coordination (ICC): is a targeted case management service that facilitates assessment of care planning for, and coordination of services to beneficiaries under age 21 who are eligible for the full scope of Medi-Cal services and who meet medical necessity criteria for this service.

Who can access these services?

1. are older adults, individuals who are hard of hearing, deaf, blind, or have other disabilities;
2. have complex or high healthcare needs, or multiple or chronic conditions,
3. have Serious and Persistent Mental Illness, or
4. are receiving Medicaid-funded long-term care services and supports (LTSS);
5. are children ages 0-5: a) Showing early signs of social/emotional or behavioral problems or; b) Have a Serious Emotional Disorder (SED) diagnosis;
6. are in medication-assisted treatment for Substance Use Disorder (SUD);
7. are women who have been diagnosed with a high-risk pregnancy;
8. are children with neonatal abstinence syndrome;
9. children in Child Welfare;
10. are IV drug users;
11. have a SUD in need of withdrawal management;
12. have HIV/AIDS or have tuberculosis;
13. are veterans and their families;
14. are at risk of first episode psychosis, or
15. individuals within the Intellectual and developmental disability (IDD) populations.

Early Assessment and Support Alliance (EASA): is a statewide network of programs which identify youth with symptoms of psychosis as early as possible, and provide support and treatment based on current research. EASA helps identify and support young people whose symptoms are consistent with the onset of a psychotic illness such as schizophrenia or bipolar disorder with psychosis. EASA also helps clarify diagnosis and appropriate treatment and supports referents in linking to appropriate care. Acute symptoms of psychosis include hallucinations (seeing and hearing things others don't); delusions (bizarre, out-of-character fixed beliefs); and disturbances to speech, emotional expression, and movement. Onset of these symptoms usually occurs gradually.

Who can access these services:

1. Age 15-25 (12-25 in Linn, Marion, Multnomah, Palk, Tillamook, and Yamhill counties)
2. IQ over 70 or not already receiving developmental disability services.
3. No more than 12 months since diagnosed with a major psychotic disorder, if applicable
4. Lives in local region
5. Symptoms not known to be caused by a medical condition or drug use.

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COMMITTEE USE ONLY

Program Eligibility Criteria & Referral Checklist		
Youth Name: Age: Date of Referral:		
All referrals to any program must meet the following 5 criteria:	Criteria Met: (check)	Notes:
Enrolled in CCO (Medicaid Eligible)		
Multi-system involvement (MH, DHS, JJ, IDD, Medical, IEP w/ED, out of mainstream placement)		
Active Mental Health Dx		
Care Coordination needs cannot be met by the other systems		
Youth and family/guardian interested and willing to engage in Wraparound process		

And at **LEAST** 2 of the following criteria:

Stable living placement has been disrupted or is at risk of disruption due to mental health/behavioral health needs		
Frequent or imminent admission to inpatient or intensive treatment services Elevated risk that disrupts activities of daily living		
Significant risk of losing school or day care placement due to behaviors related to mental health needs		
Family support system and environmental stressors impacting activities of daily living		
Or current enrollment with CCO, enrollment in one of the following programs & family interested in engaging in the Wraparound process		
Placement in Secure Adolescent Inpatient Program (SAIP), Secure Children's Inpatient Program (SCIP)		
Psychiatric Residential Treatment Services or the Commercially Sexually Exploited Children's residential program		

Approved or **Denied** Date:_____
(Circle one)

Reason for Denial:_____

_____

_____