Systems of Care Wraparound Initiative
MALHEUR COUNTY WRAPAROUND

Referral for Eligibility Determination
Phone: 541-889-9167
Email: malheurwraparound@lifeways.org

Youth Name:		Date of Referral:		DOB:		Age:	
Oregon Health Plan:	☐ Yes ☐ No		OHP Member ID:				
Private insurance in addition to OHP?	☐ Yes ☐ No If yes, private insurance carrier:						
Release of Information signed?	☐ Yes ☐ No If yes, please attach						

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

Mental Health: ☐	Intellectual Developmental Disabilities: ☐
Juvenile Justice/OYA/In Detention: ☐	Has an IEP or 504: ☐
DHS Child Welfare Involvement: ☐	Other:
Other:	Other:

Would the youth like to work with a Youth Partner?	☐ Yes ☐ No
Would the family like to work with a Family Partner?	☐ Yes ☐ No
History of/current services in place:	

Referral Source:

Name:		Relationship:			
Email:		Phone:		Fax:	

Education:

Current School:		Contact:		Phone:	

Legal Guardian:

Name:		Relationship:	
Address:		Phone:	
Email address:			
Emergency Contact:		Phone:	

Current placement/caregiver(s), if different than above:

Name:		Relationship:	
Address:		Phone:	
Email address:			

Biological family information, if different than above:

Name:		Relationship:	
Address:		Phone:	
Email address:			
Name:		Relationship:	
Address:		Phone:	
Email address:			

Strengths and needs should be described by the youth and family, in addition to the referral source

Describe the youth and family strengths:
Describe the youth and family needs:
Please give a detailed description of the behaviors and concerns that prompted this referral *(criminal history, school issues, family dynamics, current living situation, etc.):*
Cultural Considerations:

Youth Signature (required if over 14 years of age)

X_____ Date:_____

Legal Guardian Signature

X_____ Date:_____

Biological Parent Signature (if youth is in DHS custody)

X_____ Date:_____

Foster Parent Signature (if youth is in DHS custody)

X_____ Date:_____

Consent for Care Coordination Screening & Services

I understand that _____ has been referred to Wraparound and this will include a review of information and/or records regarding them.

The Wraparound Review Committee will meet to determine if they meet criteria for the Wraparound program. The review committee is made up of community partners that include Mental Health, Juvenile Department, Child Welfare, School partners, Developmental Disabilities, and potentially other invested community and state partners.

The team will review their and their family's strengths, needs, current supports, agency 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.

Potential information to be reviewed may include physical and behavioral health records, school records, and/or juvenile records. I understand that all information will be kept private and confidential unless I sign a Release of Information directing 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.

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

_____ _____

Youth Date

_____ _____

Legal Guardian Date