Greater Oregon Behavioral Health, Inc.
Eastern Oregon Coordinated Care Organization

Wraparound Review Committee Referral

Wraparound Contacts
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Email Address:
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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:

Referred by:		Relationship:			
Email:		Phone:		Fax:	

Youth and Family Information:

Current School:		Contact:		Phone:	
Current Mental Health Provider:				Phone:	
Biological Mother:				Phone:	
Address:					
Biological Father:				Phone:	
Address:					
Current Placement:		Relationship:		Phone:	
Address:					
Legal Guardian:		Relationship:		Phone:	
Address:					

Have the youth and family consented to presentation?	☐ Yes	☐ No
Have the youth and family been invited to present?	☐ Yes	☐ No
Has an ROI/Consent for the Wrap Review Committee been signed?	☐ Yes	☐ No
Would the youth like to work with a Youth Partner?	☐ Yes	☐ No
Would the family like to work with a Family Partner?	☐ Yes	☐ No

Describe the youth and family strengths:

Describe the youth and family needs:

Cultural Considerations:

Youth Signature (required if over 14 years of age) ____________________ Date ____________

Legal Guardian Signature ____________________ Date ____________

Biological Parent Signature (if youth is in DHS custody) ____________________ Date ____________

Foster Parent Signature (if youth is in DHS custody) ____________________ 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