Date of Referral: ________________

Systems of Care Wraparound Referral

Harney County Wraparound Referral

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: _________________________________ Date of Last CANS Assessment: _________

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: _________________________

Date of Referral: _________________

Harney 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:		
Youth is at risk of losing stable housing or is homeless		
Multiple Hospitalizations		
Proactive planning for youth who will be transitioning to reside in Harney County		
Multiple resources within the child serving system have been explored & the level of service need is outside "traditional services and supports"		
Dual Diagnosis of Mental Health and Developmental/ Intellectual Developmental Disabilities		
Current natural supports are unable to provide amount of support needed		

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, Franki Kesling 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.

Summary of reason for referring this youth to the Wraparound

____

Date of Referral: _________________

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?

____

CONSENT FOR CARE COORDINATION SCREENING & SERVICES

I understand that _____________________has been referred to Wraparound and this will include a review of records regarding them.

Date of Referral: _________________

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, 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: _______________

Symmetry Care Inc.

AUTHORIZATION TO USE AND DISCLOSE INFORMATION

I, ____________________, legal guardian of ____________________ Authorize Symmetry Care to:
Legal Guardian *Youth*

( ) Release Information to: ( ) Obtain Information from: ( ) Exchange Information with:

Name/Agency	Address	Phone/Fax

PURPOSE: For the purpose of Determination/review of eligibility for Mental Health Services and Care Coordination.

INFORMATION: The information that is subject to this authorization pertains to myself and includes the following:

( ) Mental Health treatment (including assessments, progress notes, and other clinical records)
( ) Alcohol and Substance abuse treatment (including assessments and other clinical records, test results)
( ) Medical (including hospitalization and treatment)
( ) Psychological/Psychiatric Evaluation records
( ) Educational Reports (including: Special Education Eligibility/IEP/School reports)
( ) Family History
( ) Other: ____.

TERM: This authorization will remain in effect:

( ) From the date of this authorization until __________ but not to exceed one year from today's date.
( ) Until the following event occurs: ____.

I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason. My refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits. I have read and understand the terms of this authorization and I have had an opportunity to ask questions about the use and disclosure of my information. I hereby, knowingly and voluntarily, authorize GOBHI to use or disclose information in the manner described above.

Date of Referral: ________________

____ ___________________________

Signature of Legal Guardian Date

____ ___________________________

Signature of Youth Date

____ ___________________________

Signature of Witness Date

Symmetry Care Inc.
Consent for Transportation

Client Name: _______________________ DOB: _____________________

I, ________________________________, __________________________________, give consent for
Parent/Guardian Name Relationship to Client

the Wraparound Care Coordinators to transport, __________________________________,
Youth Name

to and from Youth and Family Program activities as needed. Transportation will be provided in Wraparound Care Coordinator's personal vehicles or Symmetry Care company vehicles depending on availability.

I authorize and consent for GOBHI to send and receive youth information to emergency personnel in the case that it is needed or warranted, while transporting the above named youth or during Youth and Family Program activities.

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used and/or disclosed under this authorization. My consent may be revoked at any time; the only exception is when the action has already occurred as instructed in the consent. This consent will expire one year after the date of signature. I understand that if my information is released to an entity not covered by federal privacy regualtion it may be redisclosed. A copy of this form shall have the same validity as the original.

____ ________________

Parent/ Legal Guardian Signature Date

____ ________________

Youth Signature Date

____ ________________

Date of Referral: ________________

Witness Signature Date

Date of Referral: __________________