HEALTH AND HUMAN SERVICES DEPARTMENT
ADMINISTRATION – ADULT – COMMUNITY SUPPORT SERVICES – ENHANCED RESIDENTIAL OUTREACH – FAMILY & YOUTH – PUBLIC HEALTH – VETERANS & DISABILITY SERVICES
627 NE Evans Street • McMinnville, OR 97128
Phone (503) 434-7523 • Fax (503) 434-9846
TTY (800) 735-2900 • www.hhs.co.yamhill.or.us

_____
Date of Referral

Wraparound Referral Form

Referred by (Name and Agency you're from): _____Phone: _____

How did you hear about Wraparound? _____

Youth's Name: _____Phone _____ DOB: _____ Speaks English? ____

Parent/Caregiver (s) _____Phone: _____ Speaks English? ____

Guardian: _____ Phone: _____ Speaks English? ___

Youth's residence: _____

Specific Linguistic and/or Cultural needs? _____

Strengths of the of youth and family: _____

_____

What would the youth and family identify as their needs? _____

_____

What services/supports have already been put in place/attempted: _____

_____

Areas of Concern:

- ☐ Drug and Alcohol use
- ☐ Criminal activity
- ☐ Mental health issues
- ☐ Individual skills
- ☐ Transition age independent living skills
- ☐ Family/home structure
- ☐ Parenting skills
- ☐ Family relationships
- ☐ Other: _____

Agencies already involved:
☐ DHS ☐ Juvenile ☐ Drug Court ☐ Lutheran ☐ OYA ☐ Family &Youth ☐ School IEP ☐ DD ☐ Other _____

☐ Referring Provider will assist in setting up initial meeting with Care Coordinator, Family Partner, Youth Partner, Youth, and Family to orient them to Wraparound
☐This program has been explained AND requested by the youth and family

For Committee/Supervisor/Lead: ☐ Open ☐ Not Open ☐ Pending

Notes: _____

Assigned to Care Coordinator: _____Signature: _____ ***Open Date:** _____

Rev. March 2020 Return this referral to Family and Youth, Zoe Pearson and Maria Phillips

Committed to supporting safety, wellness, and dignity for all

Wraparound Eligibility Criteria and Referral

Name:	**Age:**	**Date of Referral:**
Insurance: YCCO _____	OHP Open Card _____	Private_____ None _____
	Input/notes from Referent & Family	**Screening Notes:**
All referrals to Wraparound must meet the following 5 criteria:		
Multi-system involvement (MH, DHS, JJ, DD, Medical, ED (IEP or out of mainstream placement) or at risk of multiple systems involvement to prevent further destabilization.		
Active Mental Health Assessment (within last 60 days)		
Active Mental Health DX with LOC C or D		
Please document why Care Coordination needs cannot be met by current system		
Family/Guardian and Youth are interested and willing to engage in Wraparound process		
AND meet at least 1 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		
Significant risk of losing school or day care placement due to behaviors related to mental health needs		
Elevated risk that disrupts activities of daily living		
Family support system and environmental stressors impacting activities of daily living		
Or Youth is-in one of the following programs and Family and Youth are 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		

Committed to supporting safety, wellness, and dignity for all

Revised March 2020

HEALTH AND HUMAN SERVICES DEPARTMENT
ADMINISTRATION – ADULT – COMMUNITY SUPPORT SERVICES
– ENHANCED RESIDENTIAL OUTREACH – FAMILY & YOUTH
– PUBLIC HEALTH – VETERANS & DISABILITY SERVICES
627 NE Evans Street • McMinnville, OR 97128
Phone (503) 434-7523 • Fax (503) 434-9846
TTY (800) 735-2900 • www.hhs.co.yamhill.or.us

_____
Date of Referral

Consent for Wraparound Referral:

Youth Name:_____ Date of Birth:_____

I understand that my youth has been referred to Family and Youth Wraparound and this will include a review of records about my youth

The Wraparound Review Committee will meet to decide if my youth meets 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 ERA, PSU, Family Members, and maybe other invested community partners.

I will be invited to attend the review committee (not required). A Family Partner and Youth Partner will reach out to me to explain this process and attend with me at the Review Committee if I want them to.

The team will review youth and family's strengths, needs, current supports and systems involvement. They will decide if my youth meets criteria for Wraparound. Potential information to be reviewed may include physical and mental health records, school records and juvenile court records.

I understand that all information will be kept private unless I sign a Release of Information. 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.

_____ _____
Signature of Youth **Date**

_____ _____
Signature of Legal Guardian and Relationship **Date**

Rev. March 2020

Committed to supporting safety, wellness, and dignity for all