



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:

- | | |
|---|--|
| <input type="checkbox"/> Drug and Alcohol use | <input type="checkbox"/> Family/home structure |
| <input type="checkbox"/> Criminal activity | <input type="checkbox"/> Parenting skills |
| <input type="checkbox"/> Mental health issues | <input type="checkbox"/> Family relationships |
| <input type="checkbox"/> Individual skills | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Transition age independent living skills | |

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



Oregon Family Support Network



Wraparound Eligibility Criteria and Referral

Name:		Age:		Date of Referral:	
Insurance: YCCO _____		OHP Open Card _____		Private _____	
		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					

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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

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