Date of Referral

HEALTH AND HUMAN SERVICES
Family and Youth Programs

YAMHILL COUNTY

420 NE Fifth Street, McMinnville, OR 97128 (503) 434-7462

Wraparound Referral Form

Referred by (Name and Agency from):_____Phone:_____
How did you hear about Wraparound?_____
Youth's Name: _____DOB:_____

Youth's residence: _____

Parent(s)/Guardian(s)'s Name: _____Phone: _____

Youth Speaks English? ☐ **Yes** ☐ **No** Parent Speaks English? ☐ **Yes** ☐ **No**

Specific Linguistic/Cultural needs? _____
Strengths of the 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	☐ Family/Home Structure
☐ Criminal activity	☐ Parenting Skills
☐ Mental health issues	☐ Family Relationships
☐ Individual skills	☐ Other: _____
☐ Transition age independent living skills	

Agencies already involved:

☐ DHS ☐ Juvenile ☐ Drug Court ☐ Lutheran ☐ OYA ☐ Family &Youth ☐ School IEP ☐ DD ☐ Other_____

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

For Committee/Supervisor/Lead: ☐ Approved ☐ Not Approved ☐ Modified
Assigned to: _____Signature: _____ ***Open Date:**_____
Notes: _____

Rev. 8-28-17 * CC see procedure list

Wraparound Eligibility Criteria and Referral Checklist

Name:	Age:	Date of Referral:	
	Input/notes from Referent & Family	**Screening Notes**	**Committee Approval**
All referrals to Wraparound must meet the following 5 criteria			
Enrolled in Yamhill County CCO			
Multi-system involvement (MH, DHS, JJ, DD, Medical, IEP with ED/out of mainstream placement) or at risk of multiple systems involvement to prevent further destabilization.			
Active Mental Health Dx with LOC C or D			
Care Coordination needs cannot be met by the other systems			
Family/guardian 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			
Elevated risk that disrupts activities of daily living			
Significant risk of losing school or day care placement due to behaviors related to mental health needs			
Family support system and environmental stressors impacting activities of daily living			
Or current enrollment with YCCCO, enrollment in one of the following programs and Family 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 regarding my youth.

The Wraparound Review Committee will meet to determine if my youth meets criteria for the Wraparound programs. The review committee is made up of community partners that include Mental Health, Juvenile Dept., Child Welfare, School partners, Developmental Disabilities, Oregon Family Support Partners, Youth Move Oregon, PSU, and potentially other invested community partners.

The team will review youth and family's strengths, needs, current supports and agencies involvement and determine 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.

I have been offered a family partner from OFSN to meet with me to explain this process and attend with me at the SOC Review Committee if I desire it.

Family Supported by and/or oriented by OFSN _____
Date

_____ _____
Youth Signature **Date**

_____ _____
Legal Guardian Signature Relationship **Date**

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