Wraparound Referral Form

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Integrated Health Care

Please send securely to wraparound@adaptoregon.org

You can expect to hear back from a Referral Coordinator within 1 business day of sending referral. If you do not hear from us, please call 541-670-3999.

Please print clearly.

Date of Referral: _____

Referred by: _____ Agency/role: _____
Phone: _____ Fax/Email: _____

I have consulted with the guardian about this referral and they are in agreement: ☐ Yes ☐ No

Has this youth previously been enrolled in Wraparound? ☐ Yes ☐ No

Youth Information

Youth Legal Name: _____ Affirmed Name: _____
Date of Birth: _____ Age: _____ Gender: _____ Pronouns: _____
Race/Ethnicity: _____ Tribal Affiliation: _____
Primary Language: _____
Preferred method of communication: ☐ Phone ☐ Email ☐ Text

Oregon Health Plan: ☐ Yes ☐ No If yes, OHP#: _____
Other Health Insurance: ☐ Yes ☐ No If yes, insurance carrier: _____

Does the youth have a current Intensive Care Coordinator: ☐ Yes ☐ No

Legal Guardian/Parent Information

Name: _____ Pronouns:_____Relationship: _____
Address: _____
Phone: _____ Fax/Email: _____
Primary Language: _____
Preferred method of communication: ☐ Phone ☐ Email ☐ Text

Physical Address of Youth (If Different): _____
Name of Caregiver: _____ Relationship: _____
Phone: _____ Fax/Email: _____
Preferred method of communication: ☐ Phone ☐ Email ☐ Text

Parent (if not indicated above): _____
Address: _____
Phone: _____ Fax/Email: _____
Preferred method of communication: ☐ Phone ☐ Email ☐ Text

Required Documentation (please check and include all)

- ☐ Mental Health Assessment within the last 60 days (if Medicaid youth)
- ☐ Consent for Wraparound Screening
- ☐ Authorization to Exchange and Disclose Health Information to Wrap Review Committee
- ☐ Acknowledgment of Wraparound Services
- ☐ Wraparound Review Committee Presentation Form
- ☐ Questionnaire

Additional Documentation (please include if available)

- ☐ Treatment plan/pychiatric evaulation/psychological evaluation
- ☐ Safety plan

System Involvement

Check all that apply:

☐ Mental Health ☐ Education/Special Education ☐ Child Welfare (Branch: _____)
☐ Intellectual/Developmental Disabilities ☐ Juvenile Justice/Oregon Youth Authority
☐ Substance Abuse/Addictions ☐ Complex Physical Health ☐ SAIP/SCIP (Secure Inpatient Care)
☐ Higher Level of Care ☐ Specialized Programs

Systems and Supports Information

	Provider	Phone	Fax/Email
Primary Care			
Dental Care			
Mental Health			

Current School	Grade	School Contact
IEP	**Phone**	**Fax/Email**
☐ Yes ☐ No		

Other Involved Support	Phone	Fax/Email

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STAFF USE ONLY:
☐ Wrap Review Committee ROI Received

Staff Initials _____ Date _____

Consent for Wraparound Screening

If your youth is involved with multiple systems, they may also be screened for Wraparound through the Wraparound Review Committee with your agreement.

I understand that the screening process may include a review of my youth's records from programs such as those listed below who may or may not have been involved with my youth:

Wraparound Review Committee

DHS Child Welfare	Developmental Disabilities	Adapt
Juvenile Justice	Oregon Youth Authority	Tribal
Roseburg Public Schools	CASA	UHA
Education/Special Education		

Initials (Please initial only ONE)

_____ **I consent** for my youth to be screened for Wraparound Care Coordination eligibility.

_____ **I do not consent** for my youth to be screened for Wraparound Care Coordination eligibility

I know that I can refuse to sign this consent for Wraparound Care Coordination screening and that I can withdraw my consent at any time but that actions already taken before I have withdrawn my consent cannot be revoked. I understand that participation in the screening is voluntary and hereby give my consent for my youth to participate in the screening.

Client name	Date of birth	Date
Guardian Signature (required)	Print Name	Date
Interpreter Signature (if applicable)	Print Name	Date

Revocation: I no longer authorize Wraparound Care Coordination Screening for myself or my child.

Signature of Individual/Legal Guardian (circle one) _____ Printed Name _____

Date/time:

STAFF USE ONLY
☐ Individual/legal guardian revoked verbally (phone or other)

AIH Staff Member Signature/Credential _____ Printed Name _____

Date/time:

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Authorization to Exchange and Disclose Health Information

Client name: _____ Date of birth: _____

I authorize AIH to exchange and disclose the following information with the individual/organization named below:

Initial all appropriate box(es) and give complete name and address:

___ To disclose health/medication records to:
___ To receive health/medication records from:
___ To verbally exchange health information with:

Individual/Organization: Wraparound Review Committee
Attention: Wraparound Intake
Address: 621 W Madrone St
Roseburg, Or 97470

I authorize the exchange or disclosure of the health information for the following reasons:

To determine eligibility for the AIH Wraparound Program

Information includes current medication records/medication list in addition to:
Screening information created by AIH staff and/or external medical records gathered from community providers to assist with eligibility determination for the Wraparound Program

By initialing the spaces below, I specifically authorize the disclosure of the following health information, if such information exists:

____ Drug/Alcohol diagnosis, treatment or referral information ___ Mental Health information

I may revoke this authorization in writing at any time to any AIH staff. I understand that the revocation will not apply to information that has already been disclosed in response to this authorization.

I understand Adapt (AIH) cannot guarantee information will not be re-disclosed by the authorized recipient. I am aware that if the recipient re-discloses my information, privacy protections provided by law may be lost.

I understand signing this authorization is not a condition to receive treatment, payment, or eligibility.

This authorization will expire in one (1) year or upon (insert date or event) _____

I understand what this authorization means and I am signing voluntarily.

_____
Signature of Individual/Legal Guardian (circle one) Printed Name Date

Revocation: I no longer authorize the exchange or disclosure of my health information.

_____
Signature of Individual/Legal Guardian (circle one) Printed Name Date

STAFF USE ONLY

☐Individual/legal guardian revoked verbally (phone or other):

_____
AIH staff signature Printed Name Date

621 W Madrone St • Roseburg, Oregon 97470 • Phone: 541-430-3532 Fax: 541-440-3554
Email: wraparound@adaptoregon.org

Acknowledgement of Wraparound Services

What is Wraparound?

Wraparound is an intensive, holistic method of engaging with individuals with complex needs (most typically children, youth, and their families) so that they can live in their homes and communities and realize their hopes and dreams. For more information, visit http://nwi.pdx.edu

Who is Wraparound for?

Wraparound is for youth and families. Wraparound offers a team-based planning process for youth who have complex needs and are involved in two or more child and adolescent serving systems, such as DHS Child Welfare, Developmental Disabilities, Special Education, Juvenile Justice, Mental Health, Addictions, and Physical Health. Participation in a Wraparound process is voluntary for youth and families. Investment and buy-in from youth and families is essential.

The Role of Coordinated Care Organizations

In Oregon, Wraparound is hosted by Coordinated Care Organizations, who have been asked to adhere to the principles and practices that represent fidelity Wraparound. The Coordinated Care Organizations that serve Douglas County is UHA. This document is intended for professionals making Wraparound referrals.

What's the process for making a referral?

Once AIH receives a completed referral, you and/or other professionals on the team will be scheduled to speak to the Wraparound Review Committee. The Wraparound Review Committee is made up of individuals who represent the various youth serving systems and priority populations that are served in Wraparound.

What can I expect from a Wraparound team planning process?

- The Wraparound process focuses on strengths and unmet needs; it is not about accessing intensive mental health services.
- The Wraparound Care Coordinator will want to get to know everyone on the team and make sure everyone is ready for the first team meeting.
- The Wraparound Care Coordinator will facilitate team meetings and adhere to a fidelity Wraparound team meeting agenda, which includes: introductions, ground rules, family vision, team mission, strengths, needs, prioritized needs, goals, brainstorming strategies, and action steps.
- Access to a Youth Partner and/or Family Partner, who provide peer delivered services, using their own lived experience as a way to gain mutuality. The Family Partner and Youth Partner support the Youth and Family in having their voice heard through empowerment and self-advocacy.
- Wraparound is a care planning process that includes 1-2 meetings a month for a year or more.
- Wraparound meetings include the referent, youth, family members, family or youth partner, professionals and individuals chosen by the youth and family.

I have spoken with the client(s) and they agree with a referral for a Wraparound planning process.

_____	_____	_____
Name	Role	Date

Wraparound Review Committee Presentation Form

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Youth Affirmed Name and Date of Birth	
Youth's Gender and Pronouns	
Youth's Race and Ethnicity	
Guardian(s) Name	

Formal System Involvement (check all that apply):

Mental Health ❑ Education/Special Education (IEP)❑ I/DD ❑ Juvenile Justice / OYA❑

DHS Child Welfare ❑ Substance Abuse / Addictions ❑ Complex Medical Needs❑

1) What are some strengths of your child/youth and your family? (Traditions, time together, communication, etc.)

2) Reason for Referral:

3) What are your current unmet needs and how can the Wraparound process support you and your family? (school, mental health, navigating crisis, family dynamics, etc.)

4) Please list who you would like to see on your Wraparound team, including family members, community partners and professionals.

Wraparound Review Committee Questionnaire for youth, families, and or guardians

1. What supports or service would you like that you are currently not receiving?

2. What services and supports have worked in the past?

3. What services and supports have not worked in the past?

4. Is the youth interested in Wraparound?