Wraparound Review Committee Form:

Baker County

Date of Referral Click or tap to enter a date.

REFERRAL FOR ELIGIBILITY DETERMINATION: *All requested information MUST be provided on page 1 and 2. Incomplete forms will be returned to the referrer.*

***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.*

Youth Referred to Wraparound

Youth Name: Click or tap here to enter text. D.O.B: Click or tap here to enter text. Age: Click or tap here to enter text.

Oregon Health Plan: Yes ☐ or No ☐ OHP Member ID: Click or tap here to enter text.

Does the youth have private insurance in addition to OHP: Yes ☐ No Click or tap here to enter text.

Youth and Family Information

Biological Parents:

Mother: Click or tap here to enter text. Phone: Click or tap here to enter text.

Address: Click or tap here to enter text.

Father: Click or tap here to enter text. Phone: Click or tap here to enter text.

Address: Click or tap here to enter text.

Current Placement: Click or tap here to enter text. Relationship: Click or tap here to enter text.

Phone: Click or tap here to enter text. Address: Click or tap here to enter text.

Legal Guardian: Click or tap here to enter text. Relationship: Click or tap here to enter text.

Phone: Click or tap here to enter text. Address: Click or tap here to enter text.

Please mark (X) the systems this youth and family are involved in:

System Level:	Youth	Family	Comments
Mental Health:	☐	☐	Click or tap here to enter text.
Juvenile Justice/Legal System:	☐	☐	Click or tap here to enter text.
Developmental Disabilities:	☐	☐	Click or tap here to enter text.
Medical:	☐	☐	Click or tap here to enter text.
IEP/504 or out of mainstream placement:	☐	☐	Click or tap here to enter text.
Substance Abuse:	☐	☐	Click or tap here to enter text.
DHS Child Welfare Permanency/CPS:	☐	☐	Click or tap here to enter text.
Other: (Snap benefits/TANF)	☐	☐	Click or tap here to enter text.

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Referred by: Click or tap here to enter text. Relationship to youth: Click or tap here to enter text.
Phone: Click or tap here to enter text. E-mail: Click or tap here to enter text. Fax: Click or tap here to enter text.
School: Click or tap here to enter text. Phone: Click or tap here to enter text.
Mental Health Provider: Click or tap here to enter text. Phone: Click or tap here to enter text.
Primary Care Provider: Click or tap here to enter text. Phone: Click or tap here to enter text.

Youth and family strengths:

Summary of reason youth and family being referred to Wraparound:

How will youth and family benefit from Wraparound?

Cultural Considerations:

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Wraparound Care Coordinator to complete with youth/Family:

CONSENT FOR CARE COORDINATION SCREENING & SERVICES

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

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, Oregon Family Support Partners, Youth Move Oregon, PSU, 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 EOCCO 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 Signature (required if over 14 years of age) Date

_____ _____
Legal Guardian Signature Date

_____ _____
Biological Parent Signature (if youth in DHS custody) Date

_____ _____
Foster Parent Signature (if youth is in DHS custody) Date

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COMMITTEE USE ONLY

***Wraparound Care Coordinator will present additional information to Project Review Committee during review process*

Have the youth and family consented to presentation? Yes No

Have the youth and family been invited to present? Yes No

Would the youth like to work with a Youth Partner? Yes No

Would the family like to work with a Family Partner? Yes No

Baker County Wraparound Eligibility Criteria and Referral Checklist **Name:** **Age:** **Date of Review:**		
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 and has a current Mental Health Assessment within 60 Days		
Care Coordination needs cannot be met by the other systems		
Youth and family/guardian interested and willing to engage in Wraparound process		
Additional Prioritized Criteria: Must meet 2		
Elevating risk of harm to self or others including sexualized behaviors, fire setting		
Youth is displaying emotional and behavioral issues and there are social concern that disrupt activities of daily living		

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Significant risk of losing current placement and/or multiple moves within the system; youth has no stable living environment		
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		
Psychiatric Residential Treatment Services or the Commercially Sexually Exploited Children's residential program		
Placement in Secure Adolescent Inpatient Program (SAIP), Secure Children's Inpatient Program (SCIP)		

Date Approved for Wraparound: _____

Date Denied for Wraparound: _____

Project Review Committee Recommendations for services and support: