Lake District Wellness Center

Wraparound Review Committee Referral Form

Date of Referral: _____

Youth Name: _____ D.O.B: _____ Age: _____

Oregon Health Plan: Yes ☐ No ☐ OHP Member ID: _____

Does the youth have private insurance in addition to OHP? Yes ☐ No ☐

If yes, private insurance carrier: _____

Please mark the systems this youth and their family are involved in:

A. **Mental Health** ☐
B. **Juvenile Justice Probation Officer / OYA Detention** ☐
C. **DHS Child Welfare Permanency Worker Assigned** ☐
D. **Intellectual Developmental Disabilities Services Coordinator Assigned** ☐
E. **Has an IEP or 504** ☐

Referred by: _____ Relationship: _____

Phone: _____ E-mail: _____ Fax: _____

Current School: _____ Phone: _____

Current Mental Health Provider: _____

Phone: _____ E-mail: _____ Fax: _____

Youth and Family Information

Biological Parents: _____Relationship: _____

Phone: _____ Address: _____

Current Placement: _____Relationship: _____

Phone: _____ Address: _____

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Legal Guardian: _____ Relationship: _____

Phone: _____ Address: _____

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

Describe youth and family strengths:

_____

_____

_____

Describe youth and family's needs:

_____

_____

_____

Cultural Considerations:

_____

_____

_____

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Youth Signature (required if over 14 years of age)	Date
Legal Guardian Signature	Date
Biological Parent Signature (if youth is in DHS custody)	Date
Foster Parent Signature (if youth is in DHS custody)	Date

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COMMITTEE USE ONLY

Wraparound Eligibility Criteria and Referral Checklist

Name: _____ Age: _____ Date of Referral: _____

All referrals to Wraparound must meet the following 5 criteria:	Criteria Met:	Notes:
Enrolled in CCO (Medicaid Eligible)		
Multi-system involvement (MH, DHS, JJ, IDD, Medical, IEP with ED/out of mainstream placement)		
Active Mental Health Dx		
Care Coordination needs cannot be met by the other systems		
Youth and family/guardian interested and willing to engage in Wraparound process		
AND at least 2 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 CCO, 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		

☐ Approved for Wraparound - Date: _____

☐ Denied for Wraparound – Date: _____