POLK COUNTY HEALTH SERVICES

Date of Referral : _____

Wraparound Request Form

Who is making the Request?

☐ Parent/Legal Guardian

☐ DHS Child Welfare *County:*_____ *Phone:*_____

☐ Other Agency *Name:*_____ *Phone:*_____

How did you hear about Wraparound?

_____

Youth's Name: _____Phone _____ DOB: _____ Speaks English?____

Parent/Caregiver (s) _____ Phone: _____ Speaks English?____

Legal Guardian: _____ Phone: _____ Speaks English? ____

Youth's residence:

_____

Specific Language and/or 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

☐ Criminal activity

☐ Mental health issues

☐ Individual skills

☐ Transition age independent living skills

☐ Family/home structure

☐ Parenting skills

☐ Family relationships

☐ Other: _____

Systems Involvement:

☐ DHS Child Welfare ☐Juvenile ☐ OYA ☐ Mental Health ☐ Substance Abuse/Addictions ☐Complex Physical Health
☐ School IEP ☐ Developmental Disabilities ☐SAIP/SCIP ☐ Psychiatric Residential Treatment Services (PRTS)
☐ Other _____

Parent or Legal Guardian must initial:

_____ I understand that Polk Wraparound is a for Medicaid eligible youth; This youth has the following OHP Plan:
☐ Pacific Source Marion Polk CCO: ID #_____ ☐OHP Open Card: ID #_____

_____ I understand that in order for youth to be considered for Polk Wraparound, the eligibility criteria outlined on page 2 must be met.

Polk Wraparound Eligibility Criteria

Name:		**Age:**	**Date of Request:**
			Input/notes from Referent & Family
YES	NO	All referrals to Wraparound must meet the following 5 criteria:	
☐	☐	Multi-system involvement: Mental Health, DHS, Juvenile Justice, Developmental Disabilities, Medical, Education (IEP or out of mainstream placement in school) -OR- At risk of multiple systems involvement to prevent further destabilization.	
☐	☐	Active Mental Health Assessment (within last 60 days) -OR- Youth is willing to engage in a Mental Health Assessment as part of the screening process (either with current mental health provider or with Polk County Behavioral Health if not currently enrolled with another provider)	
☐	☐	Active Mental Health DX	
☐	☐	Please describe why Care Coordination needs cannot be met by current system.	
☐	☐	Family/Guardian and Youth are interested and willing to engage in Wraparound process	
YES	NO	**-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	
YES	NO	**-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	

Consent for Polk Wraparound Screening:

Youth Name:_____ Date of Birth:_____

I understand that the Wraparound screening will include a review of my youth's records and a summary will be presented to the Wraparound Review Committee who will decide if my youth meets criteria for the Wraparound program.

The Wraparound Review committee will review the youth and family's strengths, needs, current supports and systems involvement. Potential information to be reviewed may include physical and mental health records, school records and juvenile court records.

The Wraparound Review Committee is made up of community partners that may include:

- Polk County Behavioral Health
- Juvenile Justice
- DHS Child Welfare
- School / Special Education
- Polk County Developmental Disabilities
- Oregon Family Support Partners
- Youth ERA

I understand that participation in the screening process is voluntary and by signing below, I give my permission to participate.

_____ I request that identifying information, including name and date of birth, be redacted during the screening process (please initial on the line).

_____ _____
Signature of Youth **Date**

_____ _____
Signature of Legal Guardian and Relationship **Date**

STAFF USE ONLY

Date Received:_____ Staff Name:_____

☐ ROIs collected for all "System Involvement" entities listed on page 1.