Benton County Behavioral Health Wraparound Program Referral

Please fax completed packet to 541-766-6186

Referring Party Information:

Referral being made by (Name): _____ Relationship: _____

Phone Number: _____ Agency: _____ Date of Request: _____

Referral Information:

Youth's Name: _____ Age: _____ Date of Birth: _____

OHP #: _____ School: _____ Grade: _____

Guardian: _____ Relationship: _____

Phone #: _____(Type: Cell Home Work) Alt. Phone #: _____(Type: Cell Home Work)

Guardian: _____ Relationship: _____

Phone #: _____(Type: Cell Home Work) Alt. Phone #: _____(Type: Cell Home Work)

Youth's Address: _____

Siblings and Ages: _____

Therapist: _____ Agency: _____ Phone #: _____

Qualifying Wraparound Information:

What is the reason for referral? _____

_____

_____

Specific Language/Cultural Needs: _____

Strengths of the Youth/Family: _____

_____

What does the Youth/Family identify as their needs?_____

_____

What services/supports have already been put in place/attempted_____

_____

What are the areas of concerns?

☐ Mental Health Issues ☐ Substance Use ☐ Individual Skills ☐ Peer Interactions ☐ Parenting Skills

☐ Family Dynamics/Home Structure ☐ Transition Age Skills ☐ Criminal Activity

☐ Other: _____

What systems are involved?

☐ DHS Child Welfare ☐ Juvenile Justice ☐ Oregon Youth Authority ☐ Mental Health ☐ SUD Services

☐ Complex Medical ☐ School IEP ☐ SAIP/SCIP ☐ Psychiatric Residential Treatment Services (PRTS)

☐ Other: _____

Youth's Name:	Date of Birth:	Date of Referral:

Eligibility Criteria to Determine Appropriateness for Benton County Wraparound Program

In order to be accepted into Wraparound, there are certain eligibility criteria that **must** be met. Please complete the following worksheet to determine eligibility. For any "yes" answers, please provide a brief note describing any relevant information.

Criteria Question		Comments/Details
Is the youth currently involved with multiple systems OR at risk of engagement with multiple systems? (Juvenile justice, mental health, child welfare, school supports, medical, developmental diversity, etc.)	☐ YES ☐ NO	
Is there an active Mental Health Assessment completed within the last 60 days?	☐ YES ☐ NO	
If "no" to above question, please answer: Is there a Mental Health Assessment completed within the last year?	☐ YES ☐ NO	
If "no" to above question, please answer: Is the youth willing to participate in a Mental Health Assessment?	☐ YES ☐ NO	
Does the youth have a mental health diagnosis?	☐ YES ☐ NO	
Has the youth and family been informed of what Wraparound is and is willing to engage and participate in the process?	☐ YES ☐ NO	

**Must answer "YES" to a minimum of 4 of the above questions.*

Please describe why care coordination needs cannot be met with current system.	

Criteria Question		Comments/Details
Has the stable living environment been interrupted OR at risk for interruption due to mental health needs?	☐ YES ☐ NO	
Have there been frequent or imminent admissions to inpatient or intensive treatment services?	☐ YES ☐ NO	
Is there significant risk of losing school or day care placement due to behaviors related to mental health needs?	☐ YES ☐ NO	
Are there elevated risks that disrupt daily living activities?	☐ YES ☐ NO	
Are there family support concerns or environmental stressors that impact daily living activities?	☐ YES ☐ NO	

**Must answer "YES" to a minimum of 1 of the above questions.*

Additional Criteria Question		Comments/Details
Is there current placement in SAIP (Secure Adolescent Inpatient Program) or SCIP (Secure Children's Inpatient Program)?	☐ YES ☐ NO	
Is the youth currently in PRTS (Psychiatric Residential Treatment Services) or the Commercially Sexually Exploited Children's Residential Program?	☐ YES ☐ NO	

Youth's Name:	Date of Birth:	Date of Referral:

Consent for Wraparound Review Committee Presentation

I understand that to be considered for acceptance into Benton County's Wraparound Program, a brief summary of my youth's chart and referral information will be shared with the Wraparound Review Committee who will determine if my youth meets eligibility criteria to be formally accepted into the Wraparound Program. Potential information to be shared with the committee includes mental health diagnoses, relevant medical concerns, juvenile records, school records, and any other specialty concerns that the committee should be aware of as they make their determination of acceptance.

During the presentation of the referral, the following items will be discussed:

- Youth and family's strengths and dynamics
- Systems involvement
- Current supports and services
- Care coordination needs
- Other potential resources that could benefit my youth/family

The Wraparound Review Committee is made up of community partners. I understand that on the day that my youth's referral is presented, representatives from the following agencies may be present:

- Benton County Behavioral Health
- Juvenile Justice
- DHS Child Welfare
- Old Mill Center for Children and Families
- Corvallis School District
- Philomath School District
- Linn Benton Lincoln ESD
- Trillium Family Services
- IHN-CCO
- Oregon Family Support Network
- Youth Era
- Jackson Street Youth Shelter
- Other community partners (therapists, housing entity, etc.)

Parent/Guardian please initial the following:

_____ I understand that Wraparound is a voluntary program and I am electing to submit this referral form.

_____ I understand that my youth's information will be presented to the Wraparound Review Committee.

_____ *If accepted into the program*, I understand that I will be expected to participate fully in the Wraparound process and I commit to do so.

*By signing below, I am acknowledging that I understand the purpose of this referral and am consenting for this to be formally submitted to Benton County Behavioral Health for review. I also consent to the disclosure of the information and documents referenced above to the Wraparound Review Committee.

_____ _____

Signature of Youth **Date**

_____ _____

Signature of Guardian **Date**

Referring Party please initial the following:

_____ I have attached the most recent Mental Health Assessment, Treatment Plan, and Safety Plan to this referral.

_____ I have attached a copy of the most current Guardianship paperwork (*if applicable*).

_____ I understand that I will be expected to present this referral at the upcoming CFCC meeting for this youth to be considered for Wraparound services.