HEALTH AND HUMAN SERVICES DEPARTMENT
ADMINISTRATION – ADULT – COMMUNITY SUPPORT SERVICES – ENHANCED RESIDENTIAL OUTREACH – FAMILY & YOUTH – PUBLIC HEALTH – VETERANS & DISABILITY SERVICES
420 NE 5th St • McMinnville, OR 97128
Phone (503) 434-7462 • Fax (503) 434-7335
TTY (800) 735-2900 • https://www.yamhillcounty.gov/204/Health-Human-Services

_____
Date of Referral

Wraparound Referral Form

Referred by (Name and Agency you're from): _____Phone: _____

How did you hear about Wraparound? _____

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

Parent/Caregiver(s) _____Phone: _____ Speaks English? _____

Guardian: _____ Phone: _____ Speaks English? _____

Youth's residence: _____ Email address:_____

Specific Linguistic and/or Cultural needs? _____

Pronoun: ☐ He ☐ She ☐ They ☐ No pronoun or Other: _____

Ethnicity ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Strengths of the of youth and family: _____

_____

What would the youth and family identify as their needs? _____

_____

What services/supports have already been put in place/attempted: _____

_____

Referral Reason:_____

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: _____

Agencies or Systems already involved:

☐ DHS ☐ Juvenile ☐ Drug Court ☐ Lutheran ☐ OYA ☐ Family &Youth ☐ School IEP ☐ DD ☐ Other _____

☐ Referring Provider will assist in setting up initial meeting with Care Coordinator, Family Partner, Youth Partner, Youth, and Family to orient them to Wraparound

☐ This process has been explained AND requested by the youth and family

For Committee/Supervisor/Lead: ☐ Open ☐ Not Open ☐ Pending

Notes: _____

Assigned to Care Coordinator: _____Signature: _____ ***Open Date:** _____

Committed to supporting safety, wellness, and dignity for all

Wraparound Eligibility Criteria and Referral

Name:	**Age:**	**Date of Referral:**
Insurance: YCCO _____	OHP Open Card _____	Private_____ None _____
	Input/notes from Referent & Family	**Screening Notes:**
All referrals to Wraparound must meet the following 5 criteria please indicate in the boxes:		
Multi-system involvement (MH, DHS, JJ, DD, Medical, ED (IEP or out of mainstream placement) or at risk of multiple systems involvements to prevent further destabilization. (*Write the systems involved)*		
Active Mental Health Assessment (within last 12 months) (*Indicate date completed)*		
Active Mental Health DX with LOC C or D: *(Indicate level of Care and Diagnosis)*		
Please document why Care Coordination needs cannot be met by current system		
Family/Guardian and Youth are interested and willing to engage in Wraparound process		
AND meet at least 1 of the following criteria please indicate with detail the impact on life domains		
Stable living placement has been disrupted or is at risk of disruption due to mental health/behavioral health needs		
Frequent or imminent admission for psychiatric hospitalization		
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		
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		

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Consent for Wraparound Referral:

Youth Name:_____ Date of Birth:_____

I understand that my youth has been referred to Family and Youth Wraparound and this will include a review of my youth's records and presented to the Wraparound Review Committee who will decide if my youth meets criteria for Wraparound.

The Wraparound Review Committee will look at the youth family and strengths, needs, current supports, and system involvement. Other Potential information to be reviewed may include physical and mental health records, school records and juvenile court records.

The review committee is made up of community partners that may include:

Mental Health	Juvenile Department	CASA
Child Welfare	School/Special Education Partners	Catholic Community Services
Developmental Disabilities	Oregon Family Support Network	Lutheran Community Services NW
ODHS Self Sufficiency	Yamhill Community Care Organization	

I will be invited to attend the review committee but it is not required. A Family Partner and Youth Partner will reach out to me to explain this process and attend with me at the Review Committee if I request them to.

I understand that participation is voluntary and information will be kept private unless I sign a Release of Information. Health information is protected by State and Federal law as well as Health and Human Service Policy.

I acknowledge that I have read and approved the wraparound referral. By signing below I give my permission to participate in the process of review.

_____ _____ **Date**
Signature of Youth

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

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