Health, Housing & Human Services
CLACKAMAS COUNTY

**Behavioral Health Division**

# Clackamas County Wraparound Referral Packet

Date of Referral: _____

## YOUTH INFORMATION

Youth Name: _____ Youth's Legal Name: _____

Date of Birth: _____ Age: _____ Pronouns: _____

Phone: _____ Email: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Oregon Health Plan (required): ☐Yes ☐No If yes, OHP #: _____

Other Health Insurance: ☐Yes ☐No If yes, other insurance carrier name: _____

## LEGAL GUARDIAN INFORMATION

Name: _____ Relationship to youth:_____

Address: _____

Phone: _____ Email: _____

If different, who does the youth live with?

Name: _____ Relationship to youth: _____

Address: _____

Phone: _____ Email: _____

## REFERRAL INFORMATION

Referred By: _____ Agency/ Role: _____

Phone: _____ Fax: _____

Email: _____

Is family aware that a Wraparound referral has been made? ☐Yes ☐No

Is youth (age 12+) aware that a Wraparound referral has been made? ☐Yes ☐No ☐Under age 12

## OTHER CONSIDERATIONS

Youth has previously been involved in Wraparound ☐Yes ☐No

Family's preferred language: _____

Youth and/or Family may need an interpreter during the screening and Wraparound planning process ☐Youth ☐Family

Youth and/or Family may need accommodations during the referral and wraparound planning process (large print, TTD/TTY) ☐Youth ☐Family Accommodation: _____

## SYSTEMS AND SUPPORTS INVOLVED WITH YOUTH

Systems Involved (check all that apply):

☐Mental Health Treatment

☐Special Education

☐Department of Human Services (ODHS)

☐Juvenile Justice

☐Developmental Disabilities

☐ Substance Abuse/ Addictions Treatment

☐ Complex Physical Health

☐ Secure Child or Adolescent Inpatient Program (SCIP or SAIP)

☐ Other: _____

☐ Other: _____

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# Clackamas County Wraparound
# Consent for Care Coordination Eligibility Determination and Services

Youth's Name: _____ Youth's Legal Name:_____

Date of Birth: _____ Phone: _____

Parent(s)/Guardian: _____

Your child has been referred to Clackamas County Behavioral Health Division Wraparound Program. This is a voluntary program and you can withdraw your child at any time. During the process, you will be respected and your voice will be heard.

The Wraparound referral process is three (3) steps:

- Referral forms are completed and reviewed for pre-eligibility.
- You and your child will be connected with a Wraparound Referral Coordinator to answer questions that you may have.
- You, your child, and the person who referred your child will meet with the Wraparound Review Committee. The Committee is a group of people from the child service systems across Clackamas County who decide if youth meet the criteria for Wraparound Care Coordination.

If your child is found eligible for Wraparound, a Care Coordinator will contact you to learn about the needs and goals for your child. They will help create a team of people chosen by you and your child. The team will meet often and work together to develop a Wraparound Plan of Care.

All information is kept confidential unless I sign an authorization to disclose or otherwise allowed by law.

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**By signing below**:

- You give permission for your child to participate in the Wraparound referral process to determine eligibility for the program.

- If found eligible, you consent the Wraparound Care Coordinator to provide all activities necessary for care coordination and the planning process.

- You understand that participation in the Clackamas Wraparound Program is voluntary and you can withdraw your consent at any time. Actions taken before consent has been withdrawn cannot be revoked.

| _____ | _____ | _____ |
|---|---|---|
| Signature of Parent/Guardian | Printed name | Date |
| _____ | _____ | _____ |
| Signature of Youth (over age 14) | Printed name | Date |

# Youth and Family Information Form

**Please fill out as much as you can. All of this information will be gathered before scheduling for the Wraparound Review Committee can occur.**

**Youth's Name: _____**

**Educational information:**

Current/most recent school:_____ Grade: _____

Youth has an Individualized Education Plan (IEP) or 504 Plan: ☐Yes ☐No

Other relevant educational information:

**Youth's Strengths:**

**Youth's Needs:**

**Current/recent living situation: Who does the youth live with?**

**Youth and family's goals for Wraparound: What are youth and family hoping to get out of Wraparound?**

**Additional information if needed:**

## People to be included in a Wraparound team

**Natural Supports are people or organizations in the child and family's own community, kinship, social, or spiritual networks, such as friends, extended family members, and neighbors. They are not paid.**

**Natural Support:** _____

Role: _____ ☐ Signed Release of Information

Phone:_____ Email: _____

**Natural Support:** _____

Role: _____ ☐ Signed Release of Information

Phone:_____ Email: _____

**Professional supports are people and agencies that the youth receives services from (therapist, school representative, caseworker etc.)**

**Professional Support:**_____

Role: _____ Agency: _____

Phone: _____ Fax: _____

Email: _____ ☐ Signed Release of Information

**Professional Support:**_____

Role: _____ Agency: _____

Phone: _____ Fax: _____

Email: _____ ☐ Signed Release of Information

**Professional Support:**_____

Role: _____ Agency: _____

Phone: _____ Fax: _____

Email: _____ ☐ Signed Release of Information

**Additional natural or professional supports:**

**Please submit completed Wraparound referral packet to one of the following**

**Email: wraparoundreferrals@clackamas.us**
**Fax: 503-742-5304**
**Mail: Attn: Wraparound Referral**
**2051 Kaen Road, Suite 154**
**Oregon City, Oregon 97045**

**For questions about Wraparound please call 503-742-5378 to be connected to a Referral Coordinator.**

**INTERNAL USE ONLY**

Insurance Type (check all that apply): ☐ HSO ☐ OHP Open Card ☐ Private Insurance (OHP 2nd) ☐ Trillium ☐ Private Insurance (No OHP) ☐ No Insurance

Date Referral Complete: _____ Date of Determination: _____

Screening Outcome: ☐ Approve ☐ Deny

Referral Source Notified: ☐ Yes ☐ No Family or Legal Guardian Notified: ☐ Yes ☐ No

Care Coordinator: _____ Date Assigned: _____

Signature of Wraparound staff processing referral: _____

Printed name and credentials: _____ Date: _____

Form Updated 1/24/2023

☐ Clear Form