Multnomah County
Health Department

Wraparound Referral Form

Please send securely to wraparound@multco.us or fax to 503-988-9387.

You can expect to hear back from a Referral Coordinator within 1 business day of sending referral.

Date of Referral: _____
Referred by: _____ Agency/role:_____
Phone: _____ Fax/Email:_____

I have consulted with the guardian about this referral and they are in agreement: ❑ Yes ❑ No

Has this youth previously been enrolled in Wraparound? ❑ Yes ❑ No

Youth Information

Youth Legal Name: _____ Affirmed Name: _____
Date of Birth: _____ Age: _____ Gender: _____ Pronouns: _____
Race/Ethnicity: _____ Tribal Affiliation: _____
Primary Language: _____
Phone: _____ Fax/Email: _____
Preferred method of communication: ❑ Phone ❑ Email ❑ Text

Oregon Health Plan: ❑ Yes ❑ No If yes, OHP#: _____
Other Health Insurance: ❑ Yes ❑ No If yes, insurance carrier: _____

Does the youth have a current Intensive Care Coordinator: ❑ Yes ❑ No

Legal Guardian/Parent Information

Name: _____ Relationship: _____
Address: _____
Primary Language: _____
Phone: _____ Fax/Email: _____
Preferred method of communication: ❑ Phone ❑ Email ❑ Text

Physical Address of Child (If Different):

_____
Name of Caregiver: _____ Relationship: _____
Phone: _____ Fax/Email: _____
Preferred method of communication: ❑ Phone ❑ Email ❑ Text

Parent (if not indicated above): _____
Address: _____
Phone: _____ Fax/Email: _____
Preferred method of communication: ❑ Phone ❑ Email ❑ Text

Required Documentation (Please check and include all)

☐ Mental Health Assessment completed / updated within 60 days of referral
☐ Consent for Wraparound Screening
☐ Authorization to Exchange and Disclose Health Information
☐ Acknowledgment of Wraparound Services
☐ Multnomah Wraparound Review Committee Presentation Form

Additional Documentation (Please include if available)

❑ Treatment Plan/Psychiatric Evaluation/Psychological Evaluation
❑ Safety plan

Reason for Referral

_____
_____
_____
_____
_____

System Involvement (Check all that apply)**:**

☐ Mental Health (Level of Care:_____)
☐ Special Education ☐ Child Welfare (Branch: _____)
☐ Intellectual/Developmental Disabilities ☐ Juvenile Justice/Oregon Youth Authority
☐ Substance Abuse/Addictions ☐ Complex Physical Health ☐ Secure Inpatient Care (SCIP/SAIP)
☐ Psychiatric Residential Treatment Services ☐ Commercial Sexual Exploitation of Children (SAGE)

Systems and Supports Information

	Provider	Phone	Fax/Email
Primary Care			
Dental Care			
Mental Health			

Current School	Grade	School Contact
IEP	**Phone**	**Fax/Email**
☐ Yes ☐ No		
Other Involved Support	**Phone**	**Fax/Email**

Multnomah County Health Department

Staff Initials

STAFF USE ONLY:
☐ Wrap Review Committee ROI Received

_____ _____
Date

Consent for Wraparound Screening

If your youth is involved with multiple systems, they may also be screened for Wraparound through the Wraparound Review Committee with your agreement.

I understand that the screening process may include a review of my youth's records from programs such as those listed below who may or may not have been involved with my youth:

Wraparound Review Committee

DHS Child Welfare
Juvenile Justice
Portland Public Schools
Special Education
Oregon Youth Authority
Multnomah County Behavioral Health Division
Peer Partners at OFSN, NAMI and Youth Era
Physical/Mental Health Programs in Portland
Developmental Disabilities

Initials (Please initial only ONE)

_____ **I consent** for my youth to be screened for Wraparound Care Coordination eligibility.

_____ **I do not consent** for my youth to be screened for Wraparound Care Coordination eligibility.

I know that I can refuse to sign this consent for Wraparound Care Coordination screening and that I can withdraw my consent at any time but that actions already taken before I have withdrawn my consent cannot be revoked. I understand that participation in the screening is voluntary and hereby give my consent for my youth to participate in the screening.

Youth's name | Date of birth | Date

Guardian Signature (required) | Print Name | Date

Interpreter Signature (if applicable) | Print Name | Date

Revocation: I no longer authorize Wraparound Care Coordination Screening for myself or my child.

Signature of Individual / Legal Guardian (circle one) | Printed Name

Date/time: _____

STAFF USE ONLY
☐ Individual/legal guardian revoked verbally (phone or other)

MHASD Staff Member Signature/Credential | Printed Name

Date/time: _____

209 SW 4th Ave Suite 220, Portland, Oregon 97204 • Phone: 503-988-4069 Fax: 503-988-9387
Email: wraparound@multco.us

Multnomah County
Health Department

Authorization to Exchange and Disclose Health Information

Youth's name: _____ Date of Birth:_____

I authorize the Behavioral Health Division to exchange or disclose the following information with the individual/organization named below:

Initial all appropriate boxes:

___ To disclose health/medication records to:
___ To receive health/medication records from:
___ To verbally exchange health information with:

Individual/Organization: Wraparound Review Committee
Attention: Wraparound
Address: 209 SW 4th Ave.
Portland, OR 97204

I authorize the exchange or disclosure of the health information for the following reasons:
To determine eligibility for the Behavioral Health Division's Wraparound Program

Information includes current medication records/medication list in addition to:
Screening information created by Behavioral Health Division staff and/or external medical records gathered from community providers to assist with eligibility determination for the Behavioral Health Division's Wraparound Program

By initialing the spaces below, I specifically authorize the disclosure of the following health information, if such information exists:

____ Drug/Alcohol diagnosis, treatment or referral information
____ HIV/AIDS related records
___ Genetic testing information
___ Mental Health information

I may revoke this authorization in writing at any time to any Behavioral Health Division staff. I understand that the revocation will not apply to information that has already been disclosed in response to this authorization.

I understand the Behavioral Health Division cannot guarantee information will not be re-disclosed by the authorized recipient. I am aware that if the recipient re-discloses my information, privacy protections provided by law may be lost.

I understand signing this authorization is not a condition to receive treatment, payment, or eligibility.

The authorization will expire in one (1) year or upon (insert date or event) _____

I understand what this authorization means and I am signing voluntarily.

_____

Signature of Individual / Legal Guardian (circle one) **Printed Name** **Date**

Revocation: I no longer authorize the exchange or disclosure of my health information.

_____

Signature of Individual/Legal Guardian (circle one) Printed Name Date

STAFF USE ONLY

☐ Individual/legal guardian revoked verbally (phone or other):

_____

Behavioral Health Division staff signature Printed Name Date

Acknowledgement of Wraparound Services

What is Wraparound?

Wraparound is an intensive, holistic method of engaging with individuals with complex needs (most typically children, youth, and their families) so that they can live in their homes and communities and realize their hopes and dreams. For more information, visit http://nwi.pdx.edu

Who is Wraparound for?

Wraparound is for youth and families. Wraparound offers a team-based planning process for youth who have complex needs and are involved in two or more child and youth serving systems, such as DHS Child Welfare, Developmental Disabilities, Special Education, Juvenile Justice, Mental Health, Addictions, and Physical Health. Participation in a Wraparound process is voluntary for youth and families. Investment and buy-in from youth and families is essential.

The Role of Coordinated Care Organizations

In Oregon, Wraparound is hosted by Coordinated Care Organizations, who have been asked to adhere to the principles and practices that represent fidelity Wraparound. The Coordinated Care Organizations that serve Multnomah, Clackamas, and Washington Counties are CareOregon and Trillium Centene. This document is intended for professionals making Wraparound referrals.

What's the process for making a referral?

Wraparound referrals are made to Multnomah, Clackamas, or Washington County- depending on where the youth lives. Once the County receives a completed referral, you and/or other professionals on the team will be scheduled to speak to the Wraparound Review Committee. The Wraparound Review Committee is made up of individuals who represent the various child and youth serving systems and priority populations that are served in Wraparound.

What can I expect from a Wraparound team planning process?

- The Wraparound process focuses on strengths and unmet needs; it is not about accessing intensive mental health services.
- The Wraparound Care Coordinator will want to get to know everyone on the team and make sure everyone is ready for the first team meeting.
- The Wraparound Care Coordinator will facilitate team meetings and adhere to a fidelity Wraparound team meeting agenda, which includes: introductions, ground rules, family vision, team mission, strengths, needs, prioritized needs, goals, brainstorming strategies, and action steps.
- Access to a Youth Partner (for youth 12- 17 years old) and Family Partner, who provide peer delivered services, using their own lived experience as a way to gain mutuality. The Family Partner and Youth Partner support the Youth and Family in having their voice heard through empowerment and self-advocacy.
- Wraparound is a care planning process that includes 1-2 meetings a month for about a year or more.
- Wraparound meetings include the referent, youth, family members, family or youth partner, professionals, and individuals chosen by the youth and family.

I have spoken with the client(s) and they agree with a referral for a Wraparound planning process.

Name Role Date

Multnomah Wraparound Review Committee Presentation Form

Youth's Affirmed Name and Date of Birth	
Youth's Gender and Pronouns	
Youth's Race and Ethnicity	
Guardian Name/s	

Formal System Involvement (check all that apply):

Mental Health ☐ Special Education ☐ Juvenile Justice ☐ Special Ed. ☐ Complex Medical Needs ☐

DHS / Child Welfare ☐ Substance Use / Addictions ☐ Other:_____

What are some strengths of your child/youth and your family? (Traditions, time together, communication, etc.)

What are your current unmet needs and how can the Wraparound process support you and your family? (school, mental health, navigating crisis, family dynamics, etc.)

Please list who would you want on your Wraparound team? This can include family members, friends, community partners, and professionals to name a few.

What is important to you about you and your family's values, beliefs, traditions, and identity?

Would you like a Family Partner? If so, what qualities are important to you?

Would you like a Youth Partner (Available to those 12-17 years old)? If so, what qualities are important to you?

What qualities in a Wraparound Care Coordinator are important to you?