

All information MUST be provided. Incomplete forms will be returned to the referent.



Columbia Community Mental Health Wraparound Referral

Thank you for your interest in Columbia Community Mental Health's (CCMH) Wraparound program. Wraparound is a voluntary program that provides intensive care coordination and peer support services to multi-system involved youth and their caregivers.

To be eligible for Wraparound youth need to meet the following requirements:

- Be enrolled as a Columbia Pacific Coordinated Care Organization (CPCCO) member;
- Be involved with more than one youth and family serving system;
- Experiencing complex needs that have not been met using traditional supports;
- Have completed a mental health assessment 180 days prior to this referral at CCMH or will complete a mental health assessment within two weeks of this referral submission at CCMH.

Youth are automatically eligible for the Wraparound program if they are enrolled in one of the following programs: Secure Children Inpatient Program/Secure Adolescent Inpatient Program, Psychiatric Residential Treatment Services, or a Commercial Sexually Exploited Children's residential program.

Once we receive the referral, the family and/or youth will be contacted by a Wraparound staff member to review the referral and start assessing the eligibility of the youth for Wraparound. The family and youth may be asked to complete a Columbia Community Mental Health Assessment before starting Wraparound.

If you are a professional referring a young person to Wraparound, please complete the ROI attached for your agency/program.

You can submit an application in the following ways-

Email to: wraparound@ccmh1.com

Mail to or drop off at: CCMH – Youth Wraparound Program

58646 McNulty Way

St. Helens, OR 97051

Please contact the Wraparound program directly for more information at (503) 397-7919.

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Date of Referral _____

Youth Name: _____ Youth Legal Name: _____

Age: _____ Date of Birth: _____ Race/Ethnicity: _____

Gender: _____ Pronouns Used: _____ Primary Language: _____

If 12+, best contact info (phone, email, text, etc.): _____

Tribal Affiliation: _____

Previous Wraparound involvement? Yes (Dates: _____) No

Date of last Mental Health Assessment at CCMH: _____

Columbia Pacific Coordinated Care Org. Member? Yes (Member ID: _____) No

Does youth have private insurance or another state insurance coverage? Yes No

*If yes, private insurance carrier and member ID: _____

Does the youth have a current Intensive Care Coordinator? Yes No

Please select the child and family serving systems this youth is currently working with:

- | | |
|--|---|
| <input type="checkbox"/> DHS | <input type="checkbox"/> Mental Health Treatment |
| <input type="checkbox"/> Juvenile Justice/Oregon Youth Authority | <input type="checkbox"/> Complex Physical Health |
| <input type="checkbox"/> Substance Abuse/Addictions Treatment | <input type="checkbox"/> Intellectual/ Developmental Disabilities |
| <input type="checkbox"/> Special Education | <input type="checkbox"/> Other(s) _____ |
| <input type="checkbox"/> Other(s) _____ | |

Current School: _____ Grade: _____

Does the youth have an IEP or 504 plan? Yes No

Any relevant educational information to share?

Referred by: _____ Relationship: _____

Phone: _____ Email/Fax: _____

Is the family aware of a Wraparound referral being made? Yes No

Is the youth aware of a Wraparound referral being made? Yes No Under Age 12

Reason for referral:

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Legal Guardian

Name: _____ Relationship: _____

Address: _____

Phone: _____ Email: _____

Language: _____

Current placement (if different from above)

Name: _____ Relationship: _____

Address: _____

Phone: _____ Email: _____

Language: _____

Biological Family Information (if different from above)

Name: _____ Relationship: _____

Address: _____

Phone: _____

Email: _____ Language: _____

Natural Support: _____

Role: _____ Signed Release of Information

Phone Number: _____ Email Address: _____

Natural Support: _____

Role: _____ Signed Release of Information

Phone Number: _____ Email Address: _____

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

*Please complete and return the attached Release of Information forms for individuals/providers and school listed in this application.

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CONSENT FOR CARE COORDINATION SCREENING

I understand that _____ (youth name) has been referred to CCMH’s Wraparound program (“Wraparound”) and this will include a review of records and disclosures of protected health information.

The youth and their family understand that they will be contacted by a member of the Wraparound team to get more specific information about what to expect from Wraparound and the Wraparound Review Committee. The youth and family understand that the information collected during the screening process will be disclosed to the Wraparound Review Committee as evidence of their eligibility or ineligibility for the Wraparound process.

The Wraparound Review Committee will meet to review their criteria for participation in the Wraparound program. The review committee is made up of community partners that include Mental Health, Juvenile Department, Columbia Health Services, Child Welfare, School Partners, Developmental Disabilities, Youth Era, Columbia Pacific Coordinated Care Organization (CPCCO). The team will review the youth and the family’s strengths, needs, natural supports, and agencies involvement.

If the youth and family do not meet criteria for participation in the Wraparound program or choose to opt out of participation in the Wraparound planning process, they will be offered appropriate alternative resources, including intensive care coordination through CPCCO.

Authorization:

I authorize Columbia Community Mental Health to request information including education records, juvenile court records, health records, mental health information, substance use information, intellectual and developmental disability information, for _____ (youth’s name) date of birth _____.

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information.

_____ Mental health information

_____ Drug/alcohol diagnosis, treatment, or referral information.

I understand that I do not need to sign this authorization. Refusal to sign this authorization will not adversely affect my ability to receive health care services, however, I will be ineligible to proceed into Wraparound services without this authorization. I may revoke this authorization in writing at any time. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment, or referral information.

I have read this authorization and I understand it. Unless revoked, this authorization expires at the conclusion of my wraparound review screening.

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Signature

Date

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: Description of Authority to Act for the Individual:

Legal Guardian Signature (if different from above)

Date

COLUMBIA COMMUNITY MENTAL HEALTH WRAPAROUND REFFERAL

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In this section, please do your best to answer the following questions. Your answers will help the Wraparound staff engage in a comfortable conversation with you about your needs, strengths, family, goals, etc.

What are some of your favorite things about you and your family?

Example: "We cook dinner together every weekend" or "We're huge Star Wars fans and enjoy watching new shows together."

Who are some people that you and/or your family can call on for support when things get hard?

Example: Our neighbors, the Smith's. My Best Friend, Tommy. The Youth Pastor at my Church, Pastor Joe.

What are some actions that have already been tried to meet you and your family's needs up to now?

Example: We have tried therapy, hospitals, safety planning and requesting IEP reviews with the school.

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If you had the ability to change something overnight, what would you change that would make things better for you and/or your family?

Example: I would have better tools to cope with my frustration toward Dad and he'd have tools to cope when he is frustrated with me.

What are some things we should know about your youth that would be helpful for us to build rapport with them?

Example: They are super into Fortnite and baseball. They have unlimited knowledge about the planets and get excited when given an opportunity to talk about their knowledge.

What should we know about you so that the Wraparound planning process can help support your family values and culture?

Example: Physical activity is really important to our family. We have so many meetings we have to go to everyday, but we really need to have time to be able to go on hikes or walks together during the week.

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What does your family need in order to be successful?

Example: Consistency between our providers! Everyone is doing something different and it feels like we never make any progress.

Anything else you would like to share?

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