



## **Systems of Care Wraparound Initiative MALHEUR COUNTY WRAPAROUND**

## Referral for Eligibility Determination Phone: 541-889-9167

Email: malheurwraparound@lifeways.org

Oregon Health Plan:		ı								
Private insurance in addition to OHP?	Youth Name:			I				DOB:		Age:
Release of Information signed?   Yes   No   If yes, please attach    Release mark the systems this youth and their family are involved in:	Oregon Health	Plan:	☐ Yes ☐ No		C	HP Mem	ber ID:			
Relationship:   Relationship	Private insurar	ice in ad	dition to OHP?	☐ No If yes, private insurance carrier:						
Mental Health:					s □ No If yes, please attach					
Mental Health:										
Juvenile Justice/OYA/In Detention:	Please mark th	e systen	ns this youth and thei	r family a	re invol	ved in:				
Other:  Would the youth like to work with a Youth Partner?   Yes   No Would the family like to work with a Family Partner?   Yes   No History of/current services in place:	Mental Health	: 🗆			Int	tellectual	Developme	ntal Disal	oilities:	
Other:    Other:	Juvenile Justic	e/OYA/]	In Detention: □		Has an IEP or 504: □					
Would the youth like to work with a Youth Partner?	DHS Child We	elfare Inv	volvement:		Other:					
Would the family like to work with a Family Partner?	Other:				Ot	her:				
Would the family like to work with a Family Partner?					•					
History of/current services in place:    Contact:   Phone:   Fax:	Would the you	th like to	o work with a Youth P	artner?	☐ Yes	□ No				
Referral Source:  Name:	Would the fam	ily like t	to work with a Family	Partner?	☐ Yes ☐ No					
Name: Relationship: Email: Phone: Fax:     Contact: Phone:   Fax:	History of/curr	ent serv	ices in place:							
Name: Relationship: Email: Phone: Fax:     Contact: Phone:   Fax:	·——		<u> </u>							
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Contact:   Phone:	Email:							F	ax:	
Current School:    Contact:	-							•		
regal Guardian:  Name: Relationship: Address: Phone:  Email address: Phone:  Emergency Contact: Phone:  Current placement/caregiver(s), if different than above:  Name: Relationship: Address: Phone:  Email address: Relationship: Address: Phone:  Email address: Relationship: Relationship: Address: Relationship: Address: Relationship: Address: Relationship: Address: Phone: Relationship: Address: Phone: Relationship: Address: Phone: Relationship: Address: Phone: Relationship: Address: Relationship: Address: Phone: Relationship: Phone: Relationship: Address: Phone: Relationship: Phone: Relations	Education:									
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*Strengths and needs should be described by the youth and family, in	addition to the referral source*
Describe the youth and family strengths:	
Describe the youth and family needs:	
Please give a detailed description of the behaviors and concerns that	t prompted this referral (criminal history,
school issues, family dynamics, current living situation, etc.):	
Cultural Considerations:	
Youth Signature (required if over 14 years of age)	•
X	Date:
Legal Guardian Signature	
X	Data
	<u>Date:</u>
Biological Parent Signature (if youth is in DHS custody)	
<u>X</u>	Date:
Foster Parent Signature (if youth is in DHS custody)	•
<u>X</u>	Date:



## **Consent for Care Coordination Screening & Services**

I understand that information and/or records regarding them.	has been referred to Wraparound and this will include a review of								
The Wraparound Review Committee will meet to determine if they meet criteria for the Wraparound program. The review committee is made up of community partners that include Mental Health, Juvenile Department, Child Welfare, School partners, Developmental Disabilities, and potentially other invested community and state partners.									
The team will review their and their family's strengths, needs, current supports, agency involvement, and determine if hey meet criteria for Wraparound. After the committee has met, the assigned Wraparound Care Coordinator will notify you if they have been accepted into Wraparound.									
records. I understand that all information will be ke	physical and behavioral health records, school records, and/or juvenile ept private and confidential unless I sign a Release of Information whom. Health information is protected by State and Federal law as								
I understand that participation in the screening proc participate.	cess is voluntary and by signing below I give my permission to								
Youth	Date								
Legal Guardian	Date								