Thank you for your interest in the King County Wraparound/WISe Program. Please take a moment to read the information below.

We ask that you provide as much information known at this time to help ensure that we are able to process your referral in a timely manner.

If you have any questions please feel free to call the number(s) listed below.

**Wraparound** is a team based planning process for youth with complex needs and their families designed to help produce better outcomes for youth so that they can live in their homes and communities and realize their hopes and dreams.

**What to expect during the Wraparound process:**

* A team of individuals who are relevant to the well-being of a youth (family members, service providers, school staff, community members, and natural supports) will be developed;
* This team will collaboratively develop and implement an individualized plan of care, monitor the efficacy of the plan, and work towards success over time;
* The plan of care will address youth and family needs while being family centered, strength based and culturally relevant;
* This team will meet frequently to evaluate strategies and interventions within the plan of care;
* Youth and families will have the opportunity learn a specific set of skills to carry forth the wraparound process within their community once the formal process is complete.

**Referral Checklist:**

All contact information including name, phone number and address is complete for the following:

The referent;

The youth, family, and guardian;

Child/Youth Serving Systems:

**Mental Health**

**Substance use**

**Special Education** (IEP or 504 plan)

**Department of Child and Family Services** (youth is a dependent of the state or the family has an active, on-going CPS case)

**Juvenile/Adult Justice Departments:** (probation, At-Risk-Youth (ARY) or Children in Need of Services (CHINS) petition)

**Developmental Disabilities Administration**: (youth is approved for DDA and may or may not be receiving services)

All items that apply to this youth and family have been checked in the following sections:

Potential Risk Factors;

Current levels of functioning.

The mental health therapist, all other contact people identified, and the parent/guardian are included on the Release of Information.

The release of information is signed

by the youth if 13 years old and older

by the parent/guardian if youth is under 13 years old

**Submit by fax to: King County Wraparound/WISe 206-205-1634**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Referent Information** | | | | | |
| **Referral Date** |  | **Date Received** |  | | |
| **Referring Person** |  | **Agency Name** |  | **Phone** |  |
| **Agency Address** |  | **Email** |  | **Fax** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client Information** | | | | | |
| **Youth’s Name** |  | **DOB** |  | **Age** |  |
| **Ethnicity** |  | **Gender Pronoun** | |  | |
| **Phone # 1** | Please check one Home Work Cell | **Phone # 2** | Please check one Home Work Cell | | |
| **Resides With** |  | **Relationship** |  | | |
| **Address** | **Street address:**  **City: State: Zip:** | | | | |
| **Parent/Guardian Information** | | | | | |
| **Name** |  | **Relationship** |  | | |
| **Phone # 1** | Please check one Home Work Cell | **Phone # 2** | Please check one Home Work Cell | | |
| **Address** | **Street address:**  **City: State: Zip:** | | | | |
| **Email** |  | | I give permission to be contacted by email Yes No | | |

|  |  |  |
| --- | --- | --- |
| **Household Members**  ***(Siblings, foster children, relatives, non-related persons)*** | | |
| **Name** | **Age** | **Relationship** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Eligibility & Collaborative Partners** | | | |
| **Is the youth eligible for Medicaid? (check one)** | | **YES  NO** | **Provider One #:** |
| ***Agencies and persons involved will be asked to participate on the youth and family team.***  ***The following persons/agencies are currently involved with the youth and family and/or have requested to participate on the team.*** | | | |
| **Collaborative Partners** | **Contact Person** | **Agency** | **Phone Number** |
| **\*Mental Health** |  |  |  |
| **\*Substance Use** |  |  |  |
| **\*Education** |  |  |  |
| **\*DCFS** |  |  |  |
| **\*Juvenile Justice** |  |  |  |
| **\*DDA** |  |  |  |
| Medical |  |  |  |
| Legal |  |  |  |
| Natural Support (s) |  |  |  |
| Other |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Educational Information *Current or most recent school attended*** | | | | | |
| **School Name** |  | **Home School District** | | |  |
| **Contact Person** |  | **Title** | | |  |
| **Phone** |  | **Email address** | | |  |
| **Current Grade Level** |  | **Highest Grade Completed** | |  | |
| **Date of last attendance** |  | **Youth is Currently (circle one)** | | **Enrolled** **Suspended** **Expelled** | |
| **IEP or 504 Plan (check one)** | **YES  NO If Yes, which one:** | | | | |
| **GED Completed (check one)** | **YES  NO** | | **Utilized behavioral health services at school (check one)** | | **YES  NO** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Special considerations** | | | |
| **Interpreter (check one)** | **YES  NO** | **Primary Language** |  |
| **Transportation** |  | **Child Care** |  |
| **Preferred Meeting Times** (we will do our best to honor these times) | |  | |
| **Family Strengths**  **Describe the child and family strengths**  ***(for example: traditions, activities enjoy doing together, specific talents, skills of the youth & family members)*** | | | |
|  | | | |
| **Reason For Current Wraparound Request** | | | |
|  | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Potential Risk Factors**  **(Please check all that apply to the best of your knowledge)** | | | | | | |
| **Has the youth ever:**  Had thoughts about suicide. If so, when was the last event?  Made a suicide attempt. If so, when was the last attempt?  Purposely hurt themselves or talked about hurting themselves.  If so, when was last event?  History threats or aggression towards others  If so, when was last event?  Run away from home, school, or another other place  If so for how long?  Run away in the last 30 days.  If so, how many times and for how long?  Made choices that resulted in harm to self or others.  Experienced a traumatic event | | | **In the last year has the youth:**  Exhibited inappropriate sexual behavior  Gone to ER for physical concerns.  If so how many times?  Gone to the ER for mental health concerns  If so how many times?  Been exposed to unsafe situations within their community  Been arrested. If yes, how many times?  If yes, when was the last time? | | | **In the last 30 days has the family or caregiver of the youth:**  Experienced developmental, physical  and or mental health challenges that  impact their ability to meet the youth’s  needs  Taken care of others with serious needs  aside from the youth identified in this  application  Experienced moderate to high level of  stress within the family  Been exposed to unsafe situations within  their community |
| **Current Functioning Levels** | | | | | | |
|  | **Concerns by domain: (check all that apply)** | | | **Unmet Need** | **Desired Goal** | |
| **Living Situation** | Youth’s behaviors are stressful for caregiver  Youth is at risk of out-of-home placement  Youth spent time in detention within the last year | | |  |  | |
| **Family** | Frequent arguing between youth and family members  Strained relationships between family members  Violence between family members | | |  |  | |
| **Education and Vocational** | Youth is at risk of failing classes  Youth is having behavioral difficulties at school  Youth is having difficulty with attendance | | |  |  | |
| **Legal** | Youth has been convicted of a crime If yes, #\_\_\_\_\_\_\_\_\_  Youth is on probation  Youth has broken the law even if not charged or caught | | |  |  | |
| **Mental Health** | Current known diagnosis:    How often is the child being seen? | Current Medications:    Is the youth able/willing to take medications as prescribed? | | Please describe the youth’s behaviors and symptoms you are concerned about: |  | |
| **Developmental** | Referent and/or family have concerns about  developmental delays for the youth.  Youth has pervasive developmental delays | | |  |  | |
| **Social/**  **Recreational** | Youth is experiencing an increase in peer conflicts  Youth is having difficulty making or keeping friends  Youth frequently changes friends | | |  |  | |
| **Medical** | Youth has medical problems or physical conditions  Condition(s) requires on-going medical care  Condition(s) is life threatening | | |  |  | |
| **Cultural/**  **Spiritual** | Does the youth or family report any experiences of discrimination or bias?  Does the youth ever feel conflicted about their cultural identity? | | |  |  | |
| **Drug and Alcohol** | Youth has used alcohol or other drugs in last 30 days  Youth has received treatment for alcohol or drug use  Within the last year? | | |  |  | |
| **Other** |  | | | |  | |

|  |
| --- |
| **KC MIDD Wraparound/WISe official use:**  **Date Referral Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_Meets eligibility criteria for MIDD Wraparound \_\_\_\_\_\_Meets eligibility criteria for WISe**  **\_\_\_\_\_\_ 180 MRO ITA at \_\_\_\_\_\_\_\_\_\_\_ for CLIP \_\_\_\_\_\_ CANS Score \_\_\_\_\_\_CALOCUS Score** |
| **Sent to Wraparound Delivery Team # \_\_\_\_\_\_\_\_\_\_\_ Date Sent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Coach: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Initials: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**\*Please make sure to complete the Authorization to Disclose and Redisclose Protected Health Information on the next page, page 7, and send a signed copy of page 7 with this referral.**

**Authorization To Disclose and Redisclose Protected Health Information**

Youth’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_

King County Behavioral Health and Recovery Division Wraparound represents an effort to implement system collaboration on behalf of at-risk children and youth within the boundaries of King County through the on-going efforts of families, their supports, local child serving agencies and school districts.

**I authorize the following entities to disclose and redisclose my health care information to and among themselves as applicable:**

King County Behavioral Health and Recovery Division Wraparound/WISe

King County Behavioral Health Provider Network (a list of providers is available on request)

King County Juvenile Courts

Washington State and King County Developmental Disabilities Administration

Department of Child and Family Services

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School District (please write in the youth’s home school district)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Private mental health therapist, psychiatrist, or psychologist

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Parent(s) or caregiver(s) of the youth named above

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Guardian(s) of the youth named above

**The purpose of this authorized exchange of information is to:**

* Determine eligibility for King County Behavioral Health and Recovery Division Wraparound Program.
* Coordinate a planning process leading to the development of a child and family team and an individualized plan of care.
* Evaluate the program and delivery of hi-fidelity wraparound.

**Information to be disclosed and redisclosed includes: Please check all appropriate boxes.**

|  |  |  |
| --- | --- | --- |
| Name & date of birth | Current & past mental health treatment including dates and diagnosis | Juvenile justice including charges, court dates and probation, at-risk-youth, or truancy requirements. |
| Address & phone number | Current & past medical treatment including dates and diagnosis | Current or past out-of-home placements and related service planning from Children’s Administration |
| School location, special education assessments & special education plans | Current & past substance use treatment including dates and diagnosis | Current or past assessments and service planning from Developmental Disabilities Administration |

**By signing this form, I understand:**

* When I am asked to fill out this authorization, I am entitled to a copy.
* The information disclosed and redisclosed may contain information on my current/past: Mental health, drug or alcohol use, and/or HIV status, and I authorize the disclosure and redisclosure for the purposes of this authorization.
* The information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by this rule with the exception of Alcohol and Drug Abuse records, which are protected by federal regulations that prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by my consent or as otherwise permitted by 42 CFR part 2\*.
* If I do not sign this authorization, it will not affect my ability to obtain health care services from the individual health care providers identified above, but my authorization is necessary for the King County Behavioral Health and Recovery Division Wraparound to coordinate my care and services.
* **I have the right to revoke (to end) this authorization at any time. It must be in writing and sent to either King County Behavioral Health and Recovery Division Wraparound Specialist(s) or the Behavioral Health Provider I am receiving wraparound support from. Any revocation will not take effect if action has already been taken based on the original authorization.**
* **Without my express revocation, this authorization will expire 90 days after discharge from the program.**

Youth (13+ years) Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_