CHECKLIST BEFORE SUBMITTING THE REFERRAL:

- ☐ Did the legal guardian and/or care giver sign the consent for screening page? (verbal consent is permissible)
- ☐ Did the youth (if 14 years of age or older) sign the consent for screening page? (verbal consent is permissible)
- ☐ For any boxes checked on page 4 (Wraparound Criteria page) is there accompanying information entered into the adjacent fillable field?
- ☐ If the youth has an existing Mental Health Assessment – is that assessment ready to be submitted alongside the referral?

RETURN SCREENING AND CONSENT FORMS TO:

***For members assigned to Trillium Community Health Plans submit referrals via email SM_Lane_Wrapreferrals@TrilliumCHP.com or by calling Trillium Member and Provider Services at 541-485-2155 and asking for a call from Behavioral Health. The Trillium representative can answer questions or fill out the referral over the phone.*

***For members assigned to Pacific Source Community Solutions via FAX 1-541-385-3123 (contact the Pacific Source Member Support Specialist team at 541-330-2507 to confirm receipt of a referral, or for referral assistance) or via email LaneWrap@pacificsource.com. For questions about your Wraparound referral call 541-330-2507 or 1-888-970-2507 and ask to be routed to Lane County and ask to speak with Cass Williams or someone from the Lane County Behavioral Health team.*

****Please note this referral is valid for up to three months from the date of submission. If all required components are not completed at that time, this referral will be void and the process for resubmission can begin at that point.*

Direction Service

Oregon Family Support Network

LANE COUNTY SYSTEM OF CARE
WRAPAROUND REFERRAL FORM

Date of referral: Click here to enter text

CLIENT: Click here to enter text

DOB/Age: Click here to enter text

Race/Ethnicity*: Choose an Item

**Lane County and the Wraparound Program seeks to support the marginalized members of our community and to that end and knowing how race/ethnicity disproportionately impacts minorities, we are tracking how we are supporting these minority communities.*

OHP Member ID: Click here to enter text

NAME OF PERSON WITH WHOM CLIENT LIVES: Click here to enter text

Phone: Click here to enter text

Address: Click here to enter text

Email: Click here to enter text

Relationship to youth: Click here to enter text

GUARDIAN (PERSON WHO HAS LEGAL CUSTODY): Click here to enter text

Phone: Click here to enter text

Address: Click here to enter text

Email: Click here to enter text

Relationship to youth: Click here to enter text

Language preference: Click here to enter text

REFERRING AGENCY: Click here to enter text

Name of person submitting referral: Click here to enter text

Referring person's relationship to family: Click here to enter text

Phone number of person submitting referral: Click here to enter text

Email address of person submitting referral: Click here to enter text

Describe youth and family strengths: (e.g. coping and savoring skills, resilience, optimism, family strengths, interpersonal skills, natural supports, relationship permanence, education setting, vocational, etc.)

Mental health diagnosis: (if there not a mental health diagnosis enter none.)

Describe current behaviors that interfere with youth's success across settings:

Describe current family stressors:

WRAPAROUND CRITERIA:

☐ **Age 0-20**

☐ **Oregon Health Plan Eligible:**

- ☐ Trillium Community Health Plan
- ☐ PacificSource Community Solutions – Lane

☐ **Consent for Screening signed and attached**

Involvement in two or more of the following systems:

**Be sure to include a narrative describing youth needs related to each system and a contact person*

MENTAL HEALTH: (*e.g.,youth/family main goal related to mental health; current provider; recent mental health treatment history,etc.*)

☐ Click here to enter text

☐ Mental Health assessment conducted within 12 months: ☐ *Yes* ☐ *No*

If Yes- please attach and send with this referral. If No- click the box acknowledging that you agree to have this completed within 90 days of the date of this referral.

☐ *I acknowledge*

☐ Crisis and Safety Plan on file?: ☐ *Yes* ☐ *No*

If yes and you have access to these documents, please attach and send with this referral

Enrolled in or stepped down from residential in last 6 months?: ☐ Click here to enter text (e.g.,discharge date, facility, etc.)

DEPT. YOUTH SERVICES/ OREGON YOUTH AUTHORITY: ☐ Click here to enter text

(e.g., describe any involvement with juvenile justice or legal system, contact person, etc.)

DHS CHILD WELFARE: ☐ Click here to enter text

Crossover Youth: ☐ (e.g., assigned caseworker, briefly describe involvement, etc.)

DEVELOPMENTAL DISABILITIES SERVICES: ☐ Click here to enter text

(e.g.,disabling condition,youth/family involvement and current status if known, contact person, etc.)

SUBSTANCE USE: ☐ Click here to enter text

(e.g.,specific to youth,treatment history, provider,etc.)

SCHOOL: ☐ Click here to enter text

(e.g.,school name, grade, involvement in specialized programs-IEP, 504,etc.)

COMPLEX PHYSICAL HEALTH: ☐ Click here to enter text

(e.g.,chronic physical health conditions, medical diagnosis, providers/contacts, etc.)

OTHER FAMILY SYSTEM INVOLVEMENT: ☐ Click here to enter text

e.g.,food/housing instability. immigration, employment,etc.)

WRAPAROUND REVIEW COMMITTEE

CONSENT FOR SCREENING

I understand that my youth and family are being referred for Wraparound Facilitation.

The Wraparound Review Committee will review the referral and related records from involved providers to determine if the Wraparound process is appropriate. This includes a review of needs, supports, and agency involvement. The committee is made up of representatives from Lane County Coordinated Care Organizations (Trillium Community Health Plan or PacificSource Community Solutions – Lane), Direction Service, Oregon Family Support Network (OFSN) and Lane County System of Care.

I understand that participation in Wraparound Facilitation is voluntary and by signing below I give my permission for a review of our relevant records to determine eligibility. I may review and have input on what information is included on the referral form completed by my family's referring provider. I also understand that health information is protected by federal and state law.

_____ _____

Youth Signature (required if over 14 years of age) Date

_____ _____

Legal Guardian Signature Date

If it is a barrier to obtain the youth and/or guardian signature, verbal consent is permissible. Select the box below and include the date.

☐ Verbal Consent for Screening Date of Consent:

***Please note this referral is valid for up to three months from the date of submission. If all required components are not completed at that time, this referral will be void and the process for resubmission can begin at that point.

Direction Service

Oregon Family Support Network