COLUMBIA COMMUNITY MENTAL HEALTH
SYSTEMS OF CARE WRAPAROUND REFFERAL
All information MUST be provided. Incomplete forms will be returned to the referent.

Systems of Care Wraparound Referral

Columbia Community Mental Health Wraparound

Thank you for your interest in CCMH's 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 eligible for Oregon Health Plan;
- 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 within the last 60 days.

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 and confirmation of a completed mental health assessment, a family and/or youth partner will contact the youth and their caregiver to discuss the Wraparound planning and review process.

You can submit an application in the following ways-

Email to wraparound@ccmh1.com
Fax to (503) 397-7879
Mail to:
CCMH – Youth Wraparound Program
PO Box 1234
St. Helens, OR 97051

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

Youth Birth Name: _____ Age: _____ DOB: _____
Youth Chosen Name: _____ Pronouns Used: _____
Race/Ethnicity: _____ Gender: _____ Sexuality: _____ Primary Language: _____
If 12+, best contact info (phone, SnapChat, IG, etc.): _____
Previous Wraparound involvement? ☐ Yes (Dates:_____) ☐ No

Date of last Mental Health Assessment: _____

Oregon Health Plan? ☐ Yes (Member ID:_____) ☐ No

Does youth have insurance in addition to OHP? ☐ Yes ☐ No

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

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

☐ DHS
☐ Juvenile Justice
☐ Alcohol & Drug
☐ IEP/504 (Special Education
☐ Other(s) _____
☐ Mental Health
☐ Medical
☐ Developmental Disabilities
☐ Early Intervention (IFSP)

Referred by: _____ Relationship: _____

Phone: _____ Email/Fax: _____

Current Mental Health provider: _____ Phone: _____
Primary Care Provider: _____ Phone: _____
Current School: _____ Phone: _____

Legal Guardian
Name: _____ Relationship: _____
Address: _____ Phone: _____
Email: _____ Language: _____

Emergency Contact: _____ Phone: _____

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: _____

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

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

Example: We cook dinner together every weekend.

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. They are always really supportive and kind when things seem to be falling apart.

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. Nothing seems to be working!

How do you want your service providers to work more effectively for you?

Example: I wish they would stop making us try the same thing over and over again. We need NEW ideas!

Do you feel like the providers you are working with listen to you? Please give an example of why or why not.

Example: Sometimes. I feel like most of the time they don't seem to hear us when we tell them something is a problem. They keep telling us to "give it time" but it feels like we don't have time.

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.

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?

CONSENT FOR CARE COORDINATION SCREENING

I understand that _____ (youth name) has been referred to Wraparound and this will include a review of records regarding them.

The youth and their family understand that they will be contacted by a family partner, Wraparound supervisor, and/or Wraparound coach to get more specific information about what to expect from Wraparound and the Wraparound Review Committee.

The Wraparound Review Committee will meet to determine if they meet criteria for participation in the Wraparound programs (criteria list is attached). The review committee is made up of community partners that include Mental Health, Juvenile Department, Child Welfare, School partners, Developmental Disabilities, Oregon Family Support Partners, Youth Move Oregon, CPCCO, and potentially other invested community partners. 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 a referral to Intensive Care Coordination services.

The team will review their and their family's strengths, needs, current supports and agencies involvement and determine if they meet criteria for Wraparound. After the committee has met, the assigned Wraparound Care Coordinator will notify you regarding your eligibility to participate in Wraparound along with suggested recommendations the committee has brainstormed.

Potential information to be reviewed may include physical and behavioral health records, school records and juvenile court records. I understand that all information will be kept private unless I sign a Release of Information directing CCMH what information they can share and with whom. Health information is protected by State and Federal law as well as Health and Human Service Policy.

I understand that participation in the screening process and in Wraparound is voluntary and by signing below I indicate my intention to participate.

_____ _____

Youth Signature (if over 14 years old) **Date**

_____ _____

Parent/Caregiver Signature **Date**

_____ _____

Legal Guardian Signature (if different from above) **Date**

COMMITTEE USE ONLY

All referrals to Wraparound must meet the following 5 criteria:	**Criteria Met:**	**Notes:**
Enrolled in CCO (Medicaid Eligible)		
Multi-system involvement (MH, DHS, JJ, IDD, Medical, IEP with ED/out of mainstream placement)		
Active Mental Health Diagnosis		
Complex needs cannot be met by the other systems		
Youth and family/guardian interested and willing to engage in Wraparound process		
AND at least 2 of the following criteria:		
Stable living placement has been disrupted or is at risk of disruption due to mental health/behavioral health needs		
Frequent or imminent admission to inpatient or intensive treatment services		
Elevated risk that disrupts activities of daily living		
Significant risk of losing school or day care placement due to behaviors related to mental health needs		
Family support system and environmental stressors impacting activities of daily living		
Or current enrollment with CCO, enrollment in one of the following programs and family interested in engaging in the Wraparound process		
Placement in Secure Adolescent Inpatient Program (SAIP), Secure Children's Inpatient Program (SCIP)		
Psychiatric Residential Treatment Services or the Commercially Sexually Exploited Children's residential program		

- Approved as eligible for Wraparound - Date: _____
- Youth/family is not eligible for participation in the Wraparound program at this time.

The Review Committee offered these services, supports, and strategies instead:

_____

_____

Date: _____

COLUMBIA COMMUNITY MENTAL HEALTH
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

SECTION A: The name of the person, or class of persons, who may authorize the requested use or disclosure:

I, _____, DOB: _____, or my authorized representative, authorize Columbia Community Mental Health to disclose my protected health information as described in Section B below**.** I understand that:

1. My treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this use or disclosure.
2. I am entitled to a copy of this authorization.

SECTION B: Entity authorized to receive or use the individual's protected health information:

Name or specifically describe the person and/or organization to whom you are authorizing us to disclose or who may use the protected health information described below:

Entity name:_____

Entity address:_____ Entity phone:_____

☐ Check this box if you authorize this entity to disclose the information selected below to Columbia Community Mental Health:

SECTION C: Protected health information to be used and/or disclosed:

Specifically and meaningfully describe the protected health information you are authorizing to be used or disclosed.

☐ Mental Health Records
☐ Substance Use Disorder Records
☐ Intellectual/Developmental Disability Records
☐ Referral/Treatment Status
☐ Assessment(s)
☐ Treatment Plan
☐ Progress Notes
☐ History and Physical
☐ Psychological Testing/Evaluation
☐ Coordination of Care/Communications
☐ Physician Orders/Medication List
☐ Social/Occupational Records
☐ Educational Records
☐ Information related to HIV, AIDS, Hepatitis B or Hepatitis C
☐ Lab Reports (Ex: UA, ECG, blood work, MRI/CT)
☐ Genetic Information
☐ Discharge Summary
☐ Other: _____

SECTION D: Purpose of the use or disclosure:

Describe the reason for the use or disclosure of this information.

The statement "at the request of the individual" is a sufficient description of the purpose when you initiate the authorization and do not, or elect not to, provide a statement of the purpose.

_____

_____

SECTION E: Signature:

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

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: _____

SECTION F: Prohibition of redisclosure:

This authorization is for the use or disclosure of health information involving mental health services.

NOTICE PROHIBITING REDISCLOSURE OF PROTECTED HEALTH INFORMATION

You are prohibited from making any further disclosure of this information unless expressly permitted to do so by the written consent of the person or his/her personal representative who is authorizing its use or disclosure. (ORS 179.505(14)

This authorization is for the disclosure of health information involving alcohol or drug treatment.

NOTICE PROHIBITING REDISCLOSURE OF ALCOHOL OR DRUG TREATMENT INFORMATION

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

SECTION G: Expiration and revocation:

This authorization will expire (complete one):

☐ On _____/_____/_____*

*If no expiration date is entered, this authorization will expire three (3) years from the signature date.

Right to revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will *not* affect any action you took in reliance on this authorization before you received my written notice of revocation.

Contact Office: Medical Records

Telephone: (503) 438-2165

Fax: 503-397-5373

E-mail: medicalrecords@ccmh1.com

Address: PO BOX 1234, St. Helens, OR 97051

COLUMBIA COMMUNITY MENTAL HEALTH
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

SECTION A: The name of the person, or class of persons, who may authorize the requested use or disclosure:

I, _____, DOB: _____, or my authorized representative, authorize Columbia Community Mental Health to disclose my protected health information as described in Section B below**.** I understand that:

1. My treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this use or disclosure.
2. I am entitled to a copy of this authorization.

SECTION B: Entity authorized to receive or use the individual's protected health information:

Name or specifically describe the person and/or organization to whom you are authorizing us to disclose or who may use the protected health information described below:

Entity name:_____

Entity address:_____ Entity phone:_____

☐ Check this box if you authorize this entity to disclose the information selected below to Columbia Community Mental Health:

SECTION C: Protected health information to be used and/or disclosed:

Specifically and meaningfully describe the protected health information you are authorizing to be used or disclosed.

☐ Mental Health Records
☐ Substance Use Disorder Records
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☐ Assessment(s)
☐ Treatment Plan
☐ Progress Notes
☐ History and Physical
☐ Psychological Testing/Evaluation
☐ Coordination of Care/Communications
☐ Physician Orders/Medication List
☐ Social/Occupational Records
☐ Educational Records
☐ Information related to HIV, AIDS, Hepatitis B or Hepatitis C
☐ Lab Reports (Ex: UA, ECG, blood work, MRI/CT)
☐ Genetic Information
☐ Discharge Summary
☐ Other: _____

SECTION D: Purpose of the use or disclosure:

Describe the reason for the use or disclosure of this information.

The statement "at the request of the individual" is a sufficient description of the purpose when you initiate the authorization and do not, or elect not to, provide a statement of the purpose.

_____

_____

SECTION E: Signature:

I, _____, have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: _____ Date: _____

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