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Columbia Community Mental Health Wraparound Referral

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 or be enrolled as a Columbia Pacific Coordinated Care Organization 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 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.

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
Fax to: 503-397-5373
Mail to: CCMH – Youth Wraparound Program
58646 McNulty Way
St. Helens, OR 97051

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

COLUMBIA COMMUNITY MENTAL HEALTH
WRAPAROUND REFFERAL

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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: _____

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

Does youth have insurance in addition to OHP? ☐ **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:

☐ DHS
☐ Juvenile Justice/Oregon Youth Authority
☐ Substance Abuse/Addictions Treatment
☐ Special Education
☐ Other(s) _____
☐ Mental Health Treatment
☐ Complex Physical Health
☐ Intellectual/ Developmental Disabilities
☐ 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:
_____
_____
_____
_____
_____
_____
_____
_____

COLUMBIA COMMUNITY MENTAL HEALTH
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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.

COLUMBIA COMMUNITY MENTAL HEALTH
WRAPAROUND REFFERAL

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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 Coordination Care Organization (CPCCO). The team will review their 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.

_____ _____

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
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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.

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!

COLUMBIA COMMUNITY MENTAL HEALTH
WRAPAROUND REFFERAL

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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.

COLUMBIA COMMUNITY MENTAL HEALTH
WRAPAROUND REFFERAL

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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?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

COLUMBIA COMMUNITY MENTAL HEALTH
WRAPAROUND REFFERAL

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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 type of protected health information you are authorizing to be used or disclosed.

☐ Information related to Mental Health Records
☐ Information related to Substance Use Disorder Records
☐ Information related to HIV, AIDS, Hepatitis B or Hepatitis C Records
☐ Information related to Intellectual/Developmental Disability Records

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

☐ Coordination of Care/Communications
☐ Physician Orders/Medication List
☐ Social/Occupational Records
☐ Referral/Treatment Status
☐ Assessment(s)
☐ Treatment Plan
☐ Progress Notes
☐ History and Physical
☐ Psychological Testing/Evaluation
☐ Educational Records
☐ 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 re-disclosure:

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) 438-2166

Fax: 503-397-5373

E-mail: medicalrecords@ccmh1.com

Address: 58646 McNulty Way, 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 type of protected health information you are authorizing to be used or disclosed.

☐ Information related to Mental Health Records
☐ Information related to Substance Use Disorder Records
☐ Information related to HIV, AIDS, Hepatitis B or Hepatitis C Records
☐ Information related to Intellectual/Developmental Disability Records

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

☐ Coordination of Care/Communications
☐ Physician Orders/Medication List
☐ Social/Occupational Records
☐ Referral/Treatment Status
☐ Assessment(s)
☐ Treatment Plan
☐ Progress Notes
☐ History and Physical
☐ Psychological Testing/Evaluation
☐ Educational Records
☐ 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: _____

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