WRAPAROUND REFERRAL

Family Service Coordination through Wraparound
Greene County Family and Children First Council

WHAT IS WRAPAROUND?

Wraparound is a free service for Greene County families, who might be experiencing high stress or crisis due to a single event or buildup of multiple challenges. Wraparound is a planning process that helps organize a supportive team around the child and family. Family Voice is at the center of this process because they are the expert on their family. Teams come together to address needs and challenges including: behavioral health struggles, children services contact, developmental delays, medical needs, juvenile justice involvement, psychiatric hospitalizations, problems at school, trauma, and/or youth who need help transitioning to adulthood.

WHO TO REFER?

Greene County Youth ages 0 – 21 involved with more than one agency and who is willing to participate in developing an individual Family Service Coordination plan through Wraparound.

INSTRUCTIONS FOR REFERRAL

Complete ALL pages and sections of the referral packet. Pages can be filled out by the referral source, the legal guardian, or completed together. ***Enrollment Release of Information and Household Income*** forms highlighted in yellow MUST be signed by the youth's legal guardian.

Include the following documents with the referral, if applicable:

- Treatment, service and case plans, or court documents for the youth.
- Custody paperwork, if there are designated custody or parenting arrangements.

- **Email the referral packet to:** renee.crossman@greenecountyohio.gov
  If assistance is needed with paperwork, please call Renee at: (937) 562-5600.
  Wraparound staff will reach out once the referral is received and explain the next steps.

- **IMPORTANT: ALL referral paperwork must be filled in and completed in FULL for the next process to begin.**

Please share the last page in this packet with the family so that they are aware of the next steps. Thank you!

Greene County Family and Children First
158 E. Main Street
Xenia, Ohio 45385
Phone: (937) 562-5600
Fax: (937) 562-5601

QUESTIONS?
Contact: Melissa Baughn
Wraparound Coordinator
Phone: (937) 562-5607
Email: melissa.baughn@greenecountyohio.gov

Assistance with paperwork: Renee Crossman (Admin)
Email Completed Referral Packet to: renee.crossman@greenecountyohio.gov

ENROLLMENT RELEASE OF INFORMATION FORM

Family Service Coordination through Wraparound
Greene County
Family and Children First Council

Youth's Full Name: ______________________________

Youth's Date of Birth: ______________________________

Caretaker/Legal Guardian Name(s): ______________________________

____

Relationship to Youth (son, daughter, grandchild, etc.): ______________________________

The purpose of the sharing of this information is to: Enroll in the Community Wraparound Planning Process. I, the undersigned, hereby authorize and consent to the release to share information with the Greene County Family and Children First Council, Parent Advocacy Connection, and the:

If applicable Referring Agency:		**Name:**
Phone:	**Email:**	**Length of Involvement:**

Information to be shared may include (but is not limited to):

- □ **Identifying information:** Name, birth date, gender, race, address, email, and telephone number.
- □ Name & contact information for agencies and individuals providing services to the youth/family.
- □ Case Plan documents: Individualized Education Plans (IEP's), Youth/Family Service Plans, Medical Records Psychological Evaluations, School Records (attendance, grades, etc.), Social History, Treatment/service History, Transition Plans, Vocational Assessments, and other pertinent personal information regarding the individualized named above.
- □ *Wraparound services are partially funded by the Greene County Jobs and Family Services (who requests demographic information, income-level, and benefits information) and the Greene County Mental Health and Recovery Board (who requests demographic information, income & diagnosis information).*

I understand that the Enrollment Release of Information form expires upon Wraparound case closure and I may cancel this at any time by providing written notice, which includes guardian name, the name of the youth being serviced and the effective date. Revocation of the release does not include any information, which was shared between the time that the release was signed and the receipt of the written notice to revoke.

I understand that my signing or refusing to sign this consent will not affect public benefits or services for which I am eligible.	

SIGNATURE DATE WITNESS DATE

Re-Release of information beyond that allowed by this consent is not permitted.

Greene County Family and Children First Council: Family Service Coordination through Wraparound Referral Packet
Email the completed Referral Packet to FCF Admin: renee.crossman@greenecountyohio.gov

Youth Information for Wraparound Referral

Youth's Name:	Date of Birth:	Adopted Yes or No	School:	Grade:

Race:	Ethnicity:
□ Asian □ Bi-Racial/Mixed Race □ Black/African American □ Hispanic □ Native Hawaiian/Pacific Islander □ Native American / Alaskan Native □ White or Caucasian	□ Appalachian □ Hispanic / Latino □ Other: ____________________

Gender: □ Male □ Female □ Non-binary / Other _____________________ □ Prefer Not to Answer

Does the youth identify as lesbian, gay, bisexual, or other? □ Yes □ No □ Don't Know □ Prefer Not to Answer

Education: □ Community School □ Alternative School □ Home-schooled □ Other: ___________________

Primary Language: □ English □ Spanish □ American Sign □ Other: _____________ Interpreter needed? □ Yes □ No

Current Placement Information:

Some youth may not be living at home at the time of referral due to a stay in foster care, juvenile detention, psychiatric hospitalization, treatment facility, etc. Please share where the youth is living right now.

Is the youth out of the home currently? □ No □ Yes – If Yes, please complete below:

Placement:			Contact:
Address:			Phone: ( )
City:	State:	Zip Code:	Email:

Family Information: Who makes up the family?

Guardian/Parent Name:			Guardian/Parent Name (if applicable):		
Relation:			Relation:		
Marital Status: Date of Birth:			Marital Status: Date of Birth:		
Address:					
City:	State:	Zip Code:	City:	State:	Zip Code:
Home Phone: ( ) Cell Phone: ( )			Home Phone: ( ) Cell Phone: ( )		
Employer: Work Phone: ( )			Employer: Work Phone: ( )		
Email:			Email:		
Primary Language:			Primary Language:		
Interpreter Needed? Yes No			Interpreter Needed? Yes No		

Other Household Members Names:	Date of Birth:	Relationship:	Adopted?	School:	Grade:
			Yes or No		
			Yes or No		
			Yes or No		
			Yes or No		

If you have additional family members, please attach another page.

Significant Supports (family, friends, community members, professionals, teachers, etc.)			
NAME:	RELATIONSHIP	PHONE (EXT)	EMAIL ADDRESS:

Health Information:		
□	**Mental Health**	**Provide Primary Diagnosis:**
□	**Physical Health**	**Medical Condition(s):**
□	**Does the youth have a doctor or clinic they go to for care?** □ YES □ NO	**Primary Care Doctor's Name:** ____________________ **Address:**____________________ ____________________ **Phone Number:** ____________________

Systems Involvement -- ALL supporting documentation, treatment plans, care plans and Court documents, etc. **MUST** be included in this package.
(Check the box if the youth is currently involved with these systems or has a need in the following areas.

□	Item	Details
□	**Children Services**	**History of:** □ **Abuse** □ **Neglect**
□	**Developmental Disabilities**	**Diagnosed Disability:** □ **Eligible for DD Services** □ **Has a DD Waiver** □ **Other:** ________________
□	**Juvenile Court**	Youth has been found: □ Unruly □ Delinquent □ Other Charge: __________ Is the youth on probation? □ Yes □ No
□	**Special Education**	□ 504 plan □ Evaluation Team Report □ IEP – Individual Education Plan □ RTI – Response to Invention
□	**Substance Use / Alcohol & Drugs**	Primary diagnosis: ____________________ ____________________ Substances used: ____________________ ____________________
□	**Jobs and Family Services**	□ Cash or Food Assistance □ Ohio Means Job Employment Programs □ Medicaid
□	**Other:**	

For Office Use:

Youth: ______________________________________

DOB: _______________________________________

Intake Date: _________________________________

Family Service Coordination through Wraparound
Greene County Family and Children First Council

Household Income:

Full Legal Name (Guardian/Parent or Young Adult):

____

(First Name) (Middle Name) (Last Name)

Address: ____

(Street)

___________________________________ Ohio ______________________________

(City) (Zip Code)

Telephone: _______________________________________

Complete the chart below for anyone living in your home, including yourself:

Name:	Relationship to Applicant:	Date of Birth:	Net Monthly Amount of Income:	Income Source* Write "Work" if from Employment:
1.	SELF			
2.				
3.				
4.				
5.				
6.				
7.				
8.				
Total Monthly Net Income:				

***Source of Income includes:** Work Employment Wages, Adoption Subsidy, Alimony, Child Support, Pension/Retirement Benefits, Public Assistance, Social Security Income (SSI), Social Security/Disability Income (SSDI), Unemployment Benefits, Worker's Compensation, Veterans Benefits, etc.

Check any benefits the family is currently receiving:

☐ Cash Assistance/OWF ☐ Food Stamps ☐ Medicaid ☐ Private Insurance

If Medicaid, check plan:

☐ Buckeye ☐ CareSource ☐ Molina ☐ Paramount ☐ United Health Care ☐ Other: ________________________

The signature below affirms that the above information is true and correct.

____	______________________
(Guardian/Parent or Young Adult's Signature)	**Date:**

YOUTH AND FAMILY INFORMATION

Family Service Coordination through Wraparound Greene County Family and Children First Council

1. How did you hear about Wraparound? ____

____

____

____

2.. What do you hope to accomplish? ____

____

____

____

List the positives / strengths of the youth and family (at school, at home, in community):

____

____

____

List major challenges / needs of the youth and family (at school, at home, in community):

____

____

____

List any major life events the youth / family has experienced:

____

____

____

Other Information you would like to know?

____

____

____

Email the completed Referral Packet to FCF Admin: renee.crossman@greenecountyohio.gov