



King County

Thank you for your interest in the King County Wraparound 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 email Wraparound@kingcounty.gov.

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 referral process:

- Wraparound staff will contact the referent and/or family by email or phone to gather additional information to determine eligibility
- For Medicaid eligible youth, the referent will be provided a list of WISe agencies that serve the youth/family’s area.

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 therapy**
 - Substance use treatment**
 - 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)
- 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

King County Wraparound
Behavioral Health and Recovery Division
401 Fifth Avenue, Suite 400, Seattle, WA 98104
Fax: 206-205-1634 Phone: 206-477-2652



Eligibility & Collaborative Partners

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			
Natural Support (s)			
Other			

Educational Information Current or most recent school attended

School Name		Home School District	
IEP or 504 Plan (check one)	<input type="checkbox"/> YES <input type="checkbox"/> NO If Yes, which one:	Youth is Currently (circle one)	<input type="checkbox"/> Enrolled <input type="checkbox"/> Suspended <input type="checkbox"/> Expelled

Special considerations

Interpreter (check one)	<input type="checkbox"/> YES <input type="checkbox"/> NO	Primary Language	
Transportation		Child Care	
Preferred Meeting Times (we will do our best to honor these times)			



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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

(Please include symptoms, behaviors or challenges you are concerned about regarding the child/youth you are referring)



KC MIDD Wraparound official use:

Date Referral Received: _____

Date Referral Screened: _____

_____ **Meets eligibility criteria for MIDD Wraparound**

_____ **180 MRO ITA at _____ for CLIP**

Sent to _____ Team Date Sent: _____

Coach: _____

KC Wraparound Program Manager Initials: _____

***Please make sure to complete the Authorization to Disclose and Redisclose Protected Health Information on the next page, page 6, and send a signed copy of page 6 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
- 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.

<input type="checkbox"/> Name & date of birth	<input type="checkbox"/> Current & past mental health treatment including dates and diagnosis	<input type="checkbox"/> Juvenile justice including charges, court dates and probation, at-risk-youth, or truancy requirements.
<input type="checkbox"/> Address & phone number	<input type="checkbox"/> Current & past medical treatment including dates and diagnosis	<input type="checkbox"/> Current or past out-of-home placements and related service planning from Children's Administration
<input type="checkbox"/> School location, special education assessments & special education plans	<input type="checkbox"/> Current & past substance use treatment including dates and diagnosis	<input type="checkbox"/> 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: _____

***If you are redisclosing information related to Substance Use Disorder or Treatment the information below must be included:**

42 CFR 2.32: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client. **Consent of Minor (Age 13-17):** A minor's signature is required to release information concerning chemical dependency or mental health conditions (42 CFR, Part 2; WAC 388-865, 45 CFR).