Community Wraparound

Community Wraparound forms a team around a youth or family who are struggling to stay safe, together, and/or maintain everyday life and functioning. The team works together to create, implement, and monitor a community and strength-based plan that will help the youth or family realize its vision for a better life.

Adapted from "Quality and Fidelity in Wraparound" by Janet S. Walker and Eric Burns as found in Focal Point.

Who to refer? Butler County youth and young adults ages 0-24 who have complex needs and who are interested in a **team-based approach** to develop one overall **service coordination plan** for their family. Our goal is to help youth and families have an individualized set of services, activities and supports in place that addresses the challenges they face, empowers them, and connects youth and families to their communities.

To make a referral to Community Wraparound:

1. Complete the referral packet.
   a. Parent/guardian or young adult **signs** the release of information in order for Wraparound to speak with the referral source or to be able to tell the referral source about the status of the referral.
   b. Parent/guardian or young adult must **complete and sign** household income page. Our services are paid from different funding sources depending on household income.
   c. **Attach** the most recent treatment, case or service plan, or court orders.
   d. Families who have designated custody and parenting arrangements must **include** a copy of all applicable custody paperwork.

2. Mail or Fax all of the information to:
   Family & Children First Council
   Attn: Program Assistant
   400 N. Erie Blvd., Suite A
   Hamilton, Ohio 45011
   Fax: (513) 896-2373

3. Once a referral is received, the Program Assistant will **email or call the referral source** to confirm we have received your referral. Then, the Wraparound Administrator will call you to discuss your needs and your participation in the planning process. If it seems like Wraparound will be helpful, a Wraparound Facilitator will be assigned to you to begin the planning process. Community Wraparound service coordination is available to all youth and families regardless of income. There is no cost to youth or families for Wraparound planning.

What if I have any other questions about the referral process*?*
Call Tom Jenne at the Butler County Family & Children First Council at (513) 887-5514 or email jennet@bcesc.org

BUTLER COUNTY FAMILY AND CHILDREN FIRST COUNCIL
400 N. Erie Blvd, Suite A
Hamilton, Ohio 45011
Phone (513) 887-5514 or Fax (513)-896-2373

Consent for Release of Information

_____ _____
Youth's full name *Date of Birth*

I, the undersigned, hereby authorize Butler County Family and Children First Council, BCESC, Parent Advocacy Connection, and

Referral Source Name: _____ **Agency**: _____

Phone: _____ **Email**: _____ **Length of Involvement**: _____

to release and share information regarding my (give relationship/i.e. daughter, son, grandson, self) _____.

The purpose of the sharing of this information is to: Initiate the Community Wraparound Planning Process

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

- Identifying information: name, birth date, gender, race, address and telephone number.
- Case information: Medical (except for HIV, AIDS treatment records) and social history, treatment/service history, psychological evaluations, Individualized Education Plans (IEP's), Individualized Family Service Plans, transition plans, vocational assessments, grades and attendance, and other personal information regarding the individual named above.
- Name and contact information for agencies and/or individuals involved with or providing services to the child and his/her family.
- Wraparound is partially funded by the Butler County Jobs and Family Services and demographic information and income/benefits is shared with them.
- Wraparound is partially funded by the Butler County Mental Health and Addiction Recovery Services Board and demographic information, income and primary diagnosis of youth is shared with them.
- Other: _____

I understand that the Consent for Release of Information expires 180 days from the date it is signed or earlier on the date of _____. I also understand that I may cancel this Consent for Release of Information at any time by stating so in writing with the date and my signature and delivering it to the Butler County Family & Children First Council Wraparound Office. The revocation does not include any information which has been shared between the time that I gave permission to share information and the time that it was canceled.

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.

Butler County Community Wraparound Referral Packet

Butler County Family & Children First Council
400 N. Erie Blvd., Suite A
Hamilton, Ohio 45011
513-887-5514
513-896-2373 fax
www.ButlerFCFC.org

Date: _____

Identified Youth's Name	Date of Birth	Adopted Y or N	School	Grade	Gender

Race: ☐ Asian ☐ Bi-Racial or Mixed Race ☐ Black or African American ☐ Hispanic ☐ Native Hawaiian or Pacific Islander ☐ Native American, American Indian or Alaskan Native ☐ White or Caucasian

Ethnicity: ☐ Amish ☐ Appalachian ☐ Somali ☐ Hispanic/Latino

Educational Placement: ☐ Community School ☐ Alternative School ☐ Partial Hosp. ☐ Home Instruction ☐ Home-schooled

Primary Language: ☐English ☐ Spanish ☐ American Sign ☐ _____ Interpreter needed? Yes ☐ No ☐

For youth/guardian, how did you hear about Wraparound? _____

Also, what do you hope to accomplish in the Wraparound planning process? _____

_____

_____

Who makes up the family?

Guardian Name:	Guardian Name (if applicable):
Relation: Marital Status: Date of Birth:	Relation: Marital Status: Date of Birth:
Address:	Address:
City: State:	City: State:
Zip: Home Phone:( )	Zip: Home Phone:( )
Employer:	Employer:
Work Phone:( ) Cell:( )	Work Phone:( ) Cell:( )
Email:	Email:

Is Youth out of the home currently (hospital, detention, treatment facility)? ☐Yes ☐No If yes, complete the following:

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

Other household members:	DOB	Relationship	Adopted Y or N	School	Grade

Family, friends, neighbors who provide support or are significant to Youth/Family

NAME	RELATIONSHIP	PHONE (ext)	EMAIL ADDRESS

Persons working with Youth/Family

NAME	AGENCY/ORGANIZATION (if applicable)	ROLE	PHONE (ext)	EMAIL ADDRESS

Check If Area of Need at Time of Referral			**Involvement/Services Attempted in Past Year**
☐	Children Services	History of: ☐ sexual abuse ☐ neglect ☐ physical abuse	
☐	Developmental Disabilities	Disability: Eligible for DD Services ☐	
☐	Education	Youth on IEP ☐ or 504 plan ☐ Multi-Disciplinary Truancy Team ☐	Youth is failing classes ☐ Youth suspended/expelled ☐
☐	Juvenile Court	Youth has been found unruly ☐ or delinquent☐	Dates in JDC:
☐	Mental Health	Primary diagnosis:	Hospitalizations Dates:
☐	Ohioans with Disabiliities		
☐	Physical Health	Medical condition:	Does the youth have a PCP - Primary Care Physician? Yes ☐ No ☐
☐	Rehabilitation and Corrections		
☐	Substance Abuse	Primary diagnosis:	

Tell us about the youth/family:

Describe any major events, losses or transitions for youth/family: _____

Describe youth strengths/characteristics: _____

Describe family strengths/characteristics: _____

Describe youth school/job strengths/characteristics: _____

Describe youth peer/social strengths/characteristics: _____

Describe neighborhood/community/faith involvement: _____

Describe youth's hobbies, interests, extra-curricular: _____

Describe current/past providers involved with youth/family: What was **helpful** or hasn't been helpful about them? _____

Additional Comments: _____

COMMUNITY WRAPAROUND
Butler County
Meeting Needs Using the Power of Families & Communities

For Office Use:
Youth: _____ DOB: _____ Intake Date: _____

Name:_____
(Guardian/Young Adult First) (Guardian/Young Adult Middle) (Guardian/Young Adult Last)

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			**$**	

*__Sources of income include__: Work, SSI; child support; retirement; SSDI; alimony; Unemployment Comp.; Pension; Public Assistance; Worker's Comp; Veterans benefits, adoption subsidies, etc.

Check any benefits the family is currently receiving:

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

if Medicaid, check HMO: ☐ Buckeye ☐ CareSource ☐ Molina ☐ Paramount ☐ United Healthcare

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

_____ **Date:**_____
Guardian/Young Adult(s) signature

Mail or fax the completed referral packet
ALONG WITH A COPY OF YOUR SYSTEM'S SERVICE OR CASE PLAN OR ORDERS:
Butler County FCFC, Attn: Program Assistant
400 N. Erie Blvd. Suite A, Hamilton, OH 45011 Fax 513-896-2373