



**BUTLER COUNTY FAMILY +
CHILDREN FIRST COUNCIL**

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 supports and services coordination plan for their family. Our goal is to help youth and families have an individualized set of supports, activities and services 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 the 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. Email all of the information to carrie.green@bcesc.org. Mail or fax is less preferable due to work from home requirements:
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

Consent for Initiation of Wraparound and 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.**
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 times 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

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 System is Involved or Area of Need or the at Time of Referral | | | Involvement/Services Attempted in Past Year |
|---|-------------------------------------|---|--|
| <input type="checkbox"/> | Mental Health | Provide Primary diagnosis: | |
| <input type="checkbox"/> | Physical Health | Medical condition: Health Dept. WIC <input type="checkbox"/> BCMH <input type="checkbox"/> | Does the youth have a PCP - Primary Care Physician? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> | Children Services | History of: <input type="checkbox"/> abuse <input type="checkbox"/> neglect | |
| <input type="checkbox"/> | Developmental Disabilities | Disability: Eligible for DD Services <input type="checkbox"/> | |
| <input type="checkbox"/> | Juvenile Court | Youth has been found unruly <input type="checkbox"/> or delinquent <input type="checkbox"/> | |
| <input type="checkbox"/> | Office of Ohioans with Disabilities | | |
| <input type="checkbox"/> | Rehabilitation and Corrections | | |
| <input type="checkbox"/> | Special Education | Youth on IEP <input type="checkbox"/> | 504 plan <input type="checkbox"/> Evaluation Team Report <input type="checkbox"/> RTI <input type="checkbox"/> |
| <input type="checkbox"/> | Addiction Recovery | Primary diagnosis: | |
| <input type="checkbox"/> | Jobs and Family Services | | |
| <input type="checkbox"/> | Help Me Grow | Home Visiting <input type="checkbox"/> Early Intervention <input type="checkbox"/> | |

Tell us about the youth and family:

Describe any major events, losses or transitions for youth or 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 or past service providers involved with the youth: What was **helpful** or hasn't been helpful about them?

Additional Comments: _____



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

Name: _____
 (Guardian or Young Adult First) (Guardian or Young Adult Middle) (Guardian or 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 or Young Adult's signature

Email the completed referral packet
To carrie.green@bcpsc.org
 Butler County FCFC Program Assistant