**MONROE COUNTY WRAPAROUND SERVICES**

COMMUNITY COLLABORATION TEAM



**REFERRAL PACKET**

Attached, please find a **WRAPAROUND INFORMATION SHEET** that you can share with the family you are referring to the Community Collaboration Team.

All Wraparound cases are accepted on a referral basis. To schedule a referral to the Monroe County Wraparound Initiative-Community Collaboration Team (CCT) please provide the following:

1. Fill out the attached **Referral Packet. Required forms to be filled out are indicated on each page.**
2. This Referral Packet will need to be discussed with the family you are referring. Families need to understand that they will be expected to actively participate in the Wraparound process.
3. The Parents/Legal Guardian must sign and date the Application for Services/Authorization for Release of Records prior to submitting the Referral Packet. You will also sign this form as the Witness.
4. Fax the packet (or mail) to **CMHA, fax # (734) 243-5564, Attention: Wraparound Supervisor, Kathleen Moore, Work# (734) 384-0315, email:** **kmoore@monroecmha.org** **, Fax # (734) 243-5564. Mailing address: 1001 S. Raisinville Rd., Monroe, MI 48161.**
5. After receiving your referral packet, Kathleen will call you to schedule a presentation date and time.
6. During your presentation we ask that you follow the format provided to you in the **Referral Packet**. Presentations are scheduled in 15 minute increments; it takes approximately 10 minutes to present your case information and the CCT members will take about five minutes to ask questions.
7. After your presentation, the CCT will discuss your case and determine the family’s appropriateness for Wraparound. If the team should decide that Wraparound is not the appropriate service we will provide you with referrals and/or suggestions which you can provide to your family.
8. CCT meets on the 1st & 3rd Wednesday of each month. Meeting is from 1:15 p.m. – 3:00 p.m. If you are unable to keep your appointment time, please call Kathleen & let her know.
9. As the referring source, we will ask that you sit on your family’s Wraparound team.

If there are questions regarding the process or if the family is approved for referral, please call Kathleen.

**Community Collaboration Team meets at:**

***MONROE COMMUNITY MENTAL HEALTH AUTHORITY***

***1001 S. RAISINVILLE RD. MONROE, MI 48161***

We look forward to your presentation

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*Referral Person/Source Contact Phone Number Contact Email**

**MONROE COUNTY WRAPAROUND**

**REFERRAL FORM**

**REQUIRED TO BE FILLED OUT**

**Identified Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Last First M.I.

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Street City State Zip

**Mother’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Last First M.I.

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Street City State Zip

**Father’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Last First M.I.

**Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Street City State Zip

**Other Household Members (i.e. step-parents, significant others, family friends, frequent home visitors, etc.):**

|  |  |  |  |
| --- | --- | --- | --- |
| **Names** | **D.O.B.** | **Sex** | **Relationship to Child** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Other Children in the Family:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Names** | **D.O.B.** | **Sex** | **Relationship to Child** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**REQUIRED TO BE FILLED OUT**

**Insurance/Assistance Information:**

 Medicaid HPOM Private Insurance Social Security (SSI) Food Benefits Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR REFERRAL**

 Involved in multiple systems At-risk of out of home placement

 Currently in out-of-home placement Served through other mental health services with

 minimal improvement

 Risk factors exceed capacity for Numerous providers are serving multiple children in

 traditional community-based the family and the outcomes are not being met

 options

**Please explain any further the reason/description for referral:**

**Family Goals and Strengths:**

**Agencies currently involved with the family:**

|  |  |  |
| --- | --- | --- |
| **AGENCY** | **WORKER** | **PHONE # (if known)** |
| **DHHS, Foster Care, CPS** |  |  |
| **Health Dept.** |  |  |
| **School** | **Teacher:** |  |
| **ISD** |  |  |
| **Mental Health Provider for Child** |  |  |
| **Mental Health Provider for other members of family** |  |  |
| **Courts** |  |  |
| **Other** |  |  |

Natural supports are a vital part of the Wraparound process. “Natural Supports” means personal associations and relationships typically developed in the community that enhance the quality and security of life for people. Good questions to ask yourself when identifying natural supports are: Who has been instrumental in pivotal points in your life? Whom can you count on for help?

**Below, please list those that you can think of. If accepted to Wraparound your facilitator will work with your family to expand this list.**

|  |  |  |
| --- | --- | --- |
| **PERSON/PLACE** | **NAME/RELATIONSHIP** | **PHONE #**  |
| **Church** |  |  |
| **Neighbor** |  |  |
| **Extended family members** |  |  |
| **Family friends** |  |  |
| **Landlord** |  |  |
| **Co-workers** |  |  |
| **Librarian/Other community members** |  |  |
| **Clubs/Sports/School Activities** |  |  |
| **Support/Recovery Groups** |  |  |
| **Other** |  |  |

**Are there any safety concerns our facilitator should be aware of in and around your home?**

|  |  |
| --- | --- |
|  | **Description** |
| **Weapons** |  |
| **Domestic Violence, Physical/Sexual/Emotional Abuse** |  |
| **Bedbugs, Lice, Etc.** |  |
| **Substance Use** |  |
| **Neighborhood Violence** |  |
| **Environmental Hazards (Broken windows, leaks, trip hazards, etc.)** |  |
| **Utility Shutoffs** |  |
| **Lack of Food/Clothing Needs/Pending Homelessness** |  |
| **Medical Concerns** |  |

**MONROE WRAPAROUND**

**CASE COORDINATION TEAM (CCT)**

**\*\*\*REQUIRED TO BE FILLED OUT**

APPLICATION FOR SERVICES

AND

AUTHORIZATION FOR RELEASE OF RECORDS

We would like to keep our family together, and therefore, are requesting services from Wraparound Services. We understand that in order to become part of the project, our family agrees to participate in all scheduled Wraparound Meetings. In these meetings, we will determine our needs and set goals that are important to us, as a family.

As part of the Wraparound Team, our family may become involved with many local organizations that will assist us in planning and providing supports. These local organizations include:

Monroe Department of Human Services

\*Monroe Community Mental Health Authority

Monroe County Family Court

Monroe County Intermediate School District

Monroe County Public Health Department

Community Partners (i.e. former parents, spiritual leader, etc.)

We hereby give permission for the above organizations to share this form and the information in this document. We further understand that our records will be released only to the organizations listed above. Further, we understand that these records are protected by State and Federal laws and cannot be shared without our written consent. These records are to be treated as privileged and confidential by the above organizations and the parties associated with these organizations. We understand that we have the right to revoke this Application for Services and Authorization for Release of Records at any time.

 This authorization shall remain in force for twelve (12) consecutive months from the signature date, unless specifically withdrawn in writing prior to the end of this 12 month period.

Signatures:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother/Legal Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father/Legal Guardian Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

Permission Expiration Date:

***\*Monroe Community Mental Health Authority will only release agency-prepared records***



**Safety and Confidentiality Understanding**

**For**

**Wraparound Families**

Wraparound staff members will be working closely with your family to assist you and your team in meeting your goals. Much of our contact with your family will be at your home. While we are bound to maintain strict confidentiality about information that is revealed to us in most instances, we are also required to follow the reporting requirements set forth by the State of Michigan. This means that Wraparound staff must report:

* Instances of abuse and/or neglect of children that come to our attention.
* Any threat of harm made against a person when it appears that a member of your household has the intent and/or ability to carry out that threat.

Also, in the event that a member of your household engages in violence or the threat of violence against any Monroe County interagency staff person, the Case Coordination Team (overseers of the Wraparound program) will review the matter and decide whether to stop providing Wraparound services to your family.

I have discussed this information with the referral source and understand it.

**\*\*\*REQUIRED TO BE FILLED OUT**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consumer’s Signature Date

**CASE COORDINATION TEAM**

Date of Presentation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date accepted by CCT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CCT has requested a face-face visit by a Wraparound Facilitator? Yes No

Name of visiting Wraparound Facilitator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If this referral to CCT was not eligible for services, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What referrals were provided to this family based on their ineligibility?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This case was assigned to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CASE COORDINATION TEAM SIGNATURES:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date Signature Date

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Signature Date Signature Date

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Signature Date Signature Date

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Wraparound Supervisor Date

Referral Presentation for Case Coordination Team

(All CCT Meetings take place at Monroe Community Mental Health Authority

On the 1st and 3rd Wednesdays of the month at 1:15 p.m.)

**\*\*\*This form is a guide for the presenter (Presenter to bring day of presentation)**

Date of Presentation:

Time:

Please follow this outline as a general guideline while presenting information regarding the family you are presenting. *As a reminder, referring source is recommended to participate on wraparound team.*

1. **General Family Data:**

Family Name:

Names and ages of Children:

Household Members:

Current marital/relationship status of caregivers:

Other significant relatives:

1. **Reason for referral:** Identify pertinent information (i.e. current risk factors) which generated this referral. How cooperative was family in making referral?
2. **Agencies currently involved with family**: Please identify likelihood of worker to sit on team.
3. **Family Needs:** What does family need assistance with at this time?
4. **Family Goals:** What does the family want to achieve with wraparound? What do they do well?
5. **Family Strengths:**