King County

King County Wraparound/ WISe Programs

Thank you for your interest in the King County Wraparound/WISe 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 please refer to www.kingcounty/Wraparoundwise or call 206-263-9000

Wraparound/WISe 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/WISe staff will contact the referent and/or youth and family by to gather additional information to determine eligibility based on the Child and Adolescent Needs and Strength (CANS) Screen tool.

What to expect during the Wraparound/WISe 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
Substance use
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

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All MIDD Wraparound referrals can be submitted by fax: 206-205-1634 or mailed to:
401 Fifth Ave Suite 400, Seattle, WA 98104

To request a MIDD Wraparound referral or a Wraparound with Intensive Services (WISe) screen you may contact King County Wraparound Support Staff by phone at 206-263-8957 or 206-263-9006 or by email at wraparound@kingcounty.gov

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If you are interested in WISe, referrals and requests can also be made directly to the agency serving the youth's home school district.

Please see the table below:

School districts	Agency	Contact Information
Bellevue, Lake Washington, and Northshore	Center for Human Services	Phone: 206-321-2497 or 206-554-1769 Fax:
	Sound – Bellevue Office	Phone: 425-653-4914 Fax:
Seattle, Shoreline, and Mercer Island	Community Psychiatric Clinic	TBD phone 206-250-0851
Skykomish, Riverview, Snoqualmie, Issaquah, and Tahoma	Friends of Youth	Phone: 425-292-0743 Fax:
Vashon Island, Highline, Tukwila, and Renton	Sound – Tukwila Office	Phone: 206-444-3674 206-661-0067
Kent, Enumclaw, Federal Way, and Auburn	Valley Cities	TBD - March

Fax: 206-547-5265

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*need referent address

Referent Information					
Referring Person		**Phone**		**Agency Name if applicable:**	
Relationship to Youth		**Email**			

Client Information							
Youth's Name		**DOB**		**Age**		**Gender Pronoun**	
Ethnicity		**Primary Language**				**Interpreter Needed**	☐Yes ☐ No
Phone # 1	Please check one ☐Home ☐Work ☐Cell	**Phone # 2**	Please check one ☐Home ☐Work ☐Cell				
Resides With		**Relationship**					
Address	**Street address:** **City:** **State:** **Zip:**						

Is the youth eligible for Medicaid? (check one)	☐ YES ☐ NO	**Provider One #:**

Parent/Guardian Information			
Name		**Relationship**	
Phone # 1	Please check one ☐Home ☐Work ☐Cell	**Phone # 2**	Please check one ☐Home ☐Work ☐Cell
Address	**Street address:** **City:** **State:** **Zip:**		
Email		I give permission to be contacted by email ☐Yes ☐No	

Household Members

(Siblings, foster children, relatives, non-related persons)

Name	Age	Relationship

Educational Information *Current or most recent school attended*			
School Name		**Home School District**	
IEP or 504 Plan (check one)	☐YES ☐NO If Yes, which one:	**Youth is Currently (circle one)**	☐Enrolled ☐Suspended ☐Expelled

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Collaborative Partners			
Collaborative Partners	**Contact Person**	**Agency**	**Phone Number**
***Mental Health**			
***Substance Use**			
***Education**			
***DCFS**			
***Juvenile Justice**			
***DDA**			
Natural Support (s)			
Other			

*Systems count towards the two-system requirement for MIDD Wraparound

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 and behaviors of the youth you are concerned about*	Potential Risk Factors *Please check all that apply to the best of your knowledge*
	In the last 30 days has the youth: ☐Had thoughts about suicide ☐Made a suicide attempt ☐Engaged in self-injurious behavior ☐Threatened or has been physically aggressive towards others ☐Run Away and if so, for how long?______

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MIDD Wraparound/WISe official use:

Date Referral Received: ____________ **Determination:** ____________ **Date determination made:** ____________

Program Requested:

☐ **WISe**

☐ **MIDD Wraparound**

☐ **180 MRO ITA at** ____________ **for CLIP**

WDT Enrollment Date: ____________ **OR** **King County WSS sent referral to:** ____________ **on** ____________ **(date)**

If applicable

Date New Request received ____________ *Determination:* ____________ *Date determination made:* ____________

Program Requested:

☐ *WISe*

☐ *MIDD Wraparound*

☐ *180 MRO ITA at* ____________ *for CLIP*

***Please make sure to complete the Authorization to Disclose and Redisclose Protected Health Information on the next page, page 7, and send a signed copy of page 7 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/WISe
- ☒ 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.

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