Thank you for your interest in the King County MIDD 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 please refer to www.[kingcounty.gov/wraparoundwise](https://kingcounty.gov/wraparoundwise) or call 206-263-9000

**MIDD 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.

* 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.

**Eligibility:** Children/youth up to 21 years of age, living in King County, who consent, along with their caregiver/guardian, to participate and who

* are not on or eligible for Medicaid;
* have concerning behaviors at home, school and in the community that meet clinical criteria for the program; and
* are enrolled in at least 2 of the following services: mental health therapy, substance use counseling, special education, Children’s Administration, Juvenile Justice, or Developmental Disabilities Administration.

**Additional eligibility**

* Youth, up to age 17.5, who may be may be in need of admission to a more restrictive mental health setting such as the Children's Long-term Inpatient Program (CLIP)

**To make a referral to MIDD Wraparound:**

Referrals can be sent by fax to 206-205-1634 or by mail to the following address:

401 Fifth Ave Suite 400

King County Behavioral Health and Recovery Division

MIDD Wraparound

401 Fifth Ave Suite 400

Seattle, WA 98104

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

**Referral Checklist:**

[ ]  All contact information including name, phone number and address is complete for the youth, parent/guardian and collaborative partners

[ ] The Authorization to disclose information is reviewed with the youth and parent/guardian, completed and signed by the youth if 13 years or older and/or the parent/guardian if the youth is under 13 years old.

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| **Referent Information** |
| **Referring Person** |  | **Phone** |  | **Agency Name** |  |
| **Relationship to Youth** |  | **Email** |   | **Address** |  |

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| **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: Zip:**  |
| **Parent/Guardian Information** |
| **Name** |  | **Relationship** |  |
| **Primary Language** |  | **Interpreter Needed** | [ ] **Yes** [ ]  **No** |
| **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 |

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| **Household Members*****(Siblings, foster children, relatives, non-related persons)*** |
| **Name** | **Age** | **Relationship** | **Name** | **Age** | **Relationship** |
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| **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** |  |  |  |
| **\*Special Education** |  |  |  |
| **\*DCYF** |  |  |  |
| **\*Juvenile Justice** |  |  |  |
| **\*DDA** |  |  |  |
| Natural Support (s) |  |  |  |
| Other |  |  |  |

\*Systems count towards the two-system requirement for MIDD Wraparound; acronyms defined on page 5

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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 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?\_\_\_\_\_\_ |
| **MIDD Wraparound official use:** **Date Referral Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Determination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date determination made:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Program Requested:**[ ]  **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:***[ ]  ***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.**

DCYF: Department of Children, Youth, and Families

DDA: Developmental Disabilities Administration

**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:**

[x]  King County Behavioral Health and Recovery Division Wraparound

[x]  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 WISe/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.**

|  |  |  |
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| [ ] 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_