Community Wraparound
BUTLER COUNTY FAMILY + CHILDREN FIRST COUNCIL

Wraparound is a free service for Butler County families of all income levels that organizes a team of support for youth and families with unmet needs & complex challenges including: behavioral health struggles, children services contact, developmental delays and/or medical needs, juvenile justice involvement, psychiatric hospitalizations, problems at school, trauma, and youth who need help transitioning to adulthood.

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 support and service coordination plan. Utilizing your family's unique strengths to problem-solve and plan, wraparound teams advocate with you and co-design targeted and creative help that addresses challenges more effectively.

To make a referral to Community Wraparound:

1. Complete the referral packet.
   a. ***Sign the release of information*** in order for Wraparound staff to process your referral in a timely fashion and allow us to communicate with the referral source.

   b. Complete and sign the household income page. Although there is no cost to youth or families for Wraparound planning and no income limit, some of our funders require us to track the average household income of those we serve.

   c. Attach the youth's ***treatment, case or service plan*** *(or court orders if applicable).*

   d. Include ***custody paperwork***, if your family has designated custody and/or parenting arrangements.

2. **Email the referral packet** to Program Assistant carrie.green@bcesc.org. If you need assistance with paperwork, call 513-887-5510. Due to the pandemic environment, mailing or faxing information may delay processing referrals.

3. **Once a referral is received,** the Program Assistant will ***confirm your information was received***. Next, we will call to discuss your needs and orient you to the planning process. If it seems like Wraparound is a good fit for you and your family, a Wraparound Facilitator will be assigned to you to begin the planning process.

What if I have any other questions about the process*?*
Call Wraparound Coordinator Leah Draut-Bieri at the Butler County Family & Children First Council at (513) 785-5183 or email leah.draut@bcesc.org.

BUTLER COUNTY FAMILY AND CHILDREN FIRST COUNCIL
400 N. Erie Blvd, Suite A
Hamilton, Ohio 45011
Phone (513) 887-5510 or Fax (513)-896-2373
https://www.butlerfcfc.org/

Consent for Wraparound Enrollment and Release of Information

Youth's Full Name:_____**Youth's Date of Birth:** _____

Caretaker/Legal Guardian Name(s):_____

Relationship to Youth (*son, daughter, grandchild*):_____

The purpose of the sharing of this information is to: **Enroll in the Wraparound Planning Process.**
I, the undersigned, hereby authorize and consent to the release to share information with the Butler County Family and Children First Council, Butler County Educational Service Center (BCESC), Parent Advocacy Connection, and the:

Referral Source Agency:_____

Name: _____

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

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

- ❏ Identifying information: name, birth date, gender, race, address, email, and telephone number.
- ❏ Name & contact information for agencies and individuals providing services to the youth/family.
- ❏ Case Plan docs: Individualized Education Plans (IEP's), Youth/Family Service Plans, Medical Records, Psychological Evaluations, School Records (attendance, grades, etc.), Social History, Treatment/service History, Transition Plans, Vocational Assessments, and other pertinent personal information regarding the individual named above.
- ❏ W*raparound services are partially funded by the Butler County Jobs and Family Services (who requests demographic information, income-level, and benefits information) and the Butler County Mental Health and Addiction Recovery Services Board (who requests demographic information, income and primary diagnosis of youth).*

I understand that the Consent for Release of Information expires upon Wraparound case closure. I may cancel this Consent for Enrollment and Release of Information at any time by providing written notice, which includes guardian name, the name of the youth being served and the effective date. Revocation of the release does not include any information, which was shared between the time that the release was signed and the receipt of the written notice to revoke.

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

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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(s), how did you hear about Wraparound? _____

What do you **hope** to accomplish? _____

_____

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:
Primary Language: _____ Interpreter needed? Yes No	Primary Language: _____ Interpreter needed? Yes No

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 No	School	Grade

If you have additional family members, please attach another page.

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**
☐	Mental Health	Provide **Primary diagnosis**:	
☐	Physical Health	Medical condition: Health Dept. WIC ☐ BCMH ☐	**Does the youth have a PCP - Primary Care Physician?** Yes ☐ No ☐
☐	Children Services	History of: ☐ abuse ☐ neglect	
☐	Developmental Disabilities	Disability: Eligible for DD Services ☐	
☐	Juvenile Court	Youth has been found unruly ☐ or delinquent☐	
☐	Office of Ohioans with Disabilities		
☐	Rehabilitation and Corrections		
☐	Special Education	Youth on IEP ☐	504 plan ☐ Evaluation Team Report ☐ RTI ☐
☐	Addiction Recovery	Primary diagnosis:	
☐	Jobs and Family Services		
☐	Help Me Grow	Home Visiting ☐Early Intervention ☐	

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 Information you would like to share: _____

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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, <u>including</u> 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.

_____ _____
Guardian or Young Adult's Signature Date

Email the completed referral packet to: **carrie.green@bcesc.org**
If you have questions about the application paperwork or the status of your referral,call Program Assistant:
Carrie Green at 513-887-5510.