



**CME
Forms & Function
Instructional
Guide**

The Cheat Sheet

Version 1.2, April 2010

Wraparound Evaluation Data Collection Timeline

Time	Event
Within 1 business day of referral	Referral form entered into database by Database Manager (DM)
Within 5 business days of referral	Non-Waiver Enrollment Criteria entered into database
<i>For CBAY:</i>	
<i>Day of notification from State CBAY office</i>	<i>Authorization packet emailed to DM. (DM establishes record in dbase within 1 business day)</i>
Within 2 business days of any family contact of 8 minutes or more	Wrap Note entered into dbase
Within 2 business days of first F2F	Copy of ROI to DM (entered by DM within 2 business days of receipt)
Within 8 business days of referral	Intake Information and CIS entered into database; TRAC baseline data entered
Within 24 hours of CFT	Wraparound Action Plan entered into dbase
Within 5 business days of CFT	First/Ongoing Fidelity Check entered into database
Last day of the month	Ongoing Columbia Impairment Scale entered into database
5 th of each month	All data entry complete for previous month
Every 90 days from enrollment (CBAY)	YSS due ; MDS submitted for TPA reauthorization
Every 6-months from enrollment (Non-Waiver, SAMHSA)	YSS due, TRAC data due
November 15 (Non-waiver, Expansion)	Semi-annual YSS administration
May 15 (Non-waiver, Expansion)	Annual YSS administration



Data flow for WIN GA Wraparound Evaluation

There are two primary pathways into Wraparound services:

1. Referral
2. CBAY

Youth entering Wraparound via referral receive the full data collection process outlined below. Youth entering Wraparound via CBAY have a few exceptions to the data collection process, described in more detail below.

INITIAL REFERRAL

1. **Referral Form** received by Care Coordinator (CC)
2. Every referral form faxed/emailed to Database Manager immediately upon receipt
3. Database Manager enters the referral form into the database within 1 business day of referral receipt
4. CC completes **Non-Waiver Enrollment Criteria** form, and makes first family contact within 24 hours of referral;
5. CC has first face-to-face meeting (F2F) with family within 72 hours of referral; CC follows up with referring party on disposition (did not meet criteria, enrolled, refused, no space available);
6. CC finalizes Enrollment Criteria Form in database within 5 business days of referral.

Exceptions:

CBAY -- No Referral Form or Non-Waiver Criteria Form for CBAY youth. CBAY Coordinator emails Database Manager authorization packet from state CBAY office for a new CBAY youth as soon as CC is assigned; Database Manager establishes new youth record in dbase within 1 business day of receiving email from CBAY Coordinator; CBAY Coordinator enters PRTF provider information into APS website. CC contacts family within 24 hrs of notification from state CBAY office, and holds first F2F within 72 hours.

The remainder of the data collection process applies uniformly to all youth (regardless of CBAY enrollment). At the first F2F the Care Coordinator completes the Crisis/Safety Plan, Release of Information (ROI), Wraparound Intake Form, and Columbia Impairment Scale, as described on the following pages. Additionally, a Wraparound Note is completed at any family contact longer than 8 minutes.



1ST FACE-TO-FACE

1. **Release of Information (ROI)** completed in hardcopy (*see ROI administration instructions*) and placed in the youth's file. A photocopy of the signed ROI should be provided to the family. The Database Manager will also receive a photocopy of the ROI within 2 business days of the first F2F;
2. ROI entered into database by Database Manager within 2 business days of receipt;
3. **Crisis/Safety Plan** is completed at the first F2F but is not housed in the database – completion and storage of paper and electronic versions is determined by WIN GA policy;
4. **Wraparound Intake Form** entered into database within 2 business days of F2F meeting;
5. **Columbia Impairment Scale (CIS)** administered, and entered into database within 2 business days of F2F meeting;
 - a. Caregiver is respondent for CIS
 - b. CC administers CIS by giving caregiver the form, explaining the purpose and confidentiality, and offer assistance with any questions (*see CIS administration instructions*).

Regardless of whether there are one or two F2F meetings prior to Child & Family Team Meeting (CFT), the ROI, Intake Form, and CIS should be entered into database within 8 business days of referral.

The initial F2F meeting(s) is followed by the first Child & Family Team Meeting (CFT), which must take place within 14 days of referral. At or following the first CFT, the initial Wraparound Action Plan (WRAP) and the First Fidelity Check (FC) are completed.

CHILD AND FAMILY TEAM (CFT) MEETING

1. **Initial Wraparound Action Plan (WRAP)** entered into the database by the Care Coordinator and submitted to the Wraparound Supervisor within 24 hours of CFT;
2. **The First Fidelity Check (FC)** is entered into database within 5 business days by the Care Coordinator, pulling info from Wraparound Notes and the WRAP; First FC entered into database within 5 business days of the CFT;
3. Families in SAMHSA-funded counties invited to participate in longitudinal study (*see Script to Introduce National Evaluation.*)

CONTINUING SERVICES

After the first Child and Family Team Meeting, the following forms are completed on an ongoing basis:

1. **Wraparound Notes** – Completed by CC for each family contact lasting more than 8 minutes and entered into database within 2 business days of contact;
2. **WRAP and Ongoing FC** – Completed after each CFT as described above.
3. **Columbia Impairment Scale (CIS)** -- Caregiver completes CIS each month before the CFT; CC enters CIS into database by the last day of the month.
4. **Youth Services Survey (YSS)** – a hardcopy version of the form is provided by CCs to families, along with a self-addressed, stamped envelope, and a voucher for a \$5 gift card in return for completed surveys. Families are asked to complete the survey and return it by mail and can obtain their gift card by bringing the voucher to their next CFT meeting. The schedule for YSS administration varies depending upon whether the youth is enrolled in CBAY, and, in SAMHSA counties, whether the youth is enrolled in the longitudinal study for the national evaluation. The YSS schedule is outlined below:

		Longitudinal study enrolled?	CBAY enrolled?	YSS Administration Schedule
SAMHSA	No	Yes		CCs administer YSS every 90 days from date of enrollment
	Yes	Yes		Interviewers from the evaluation team administer YSS for the two 90 day administrations that coincide with 6-month longitudinal study interviews; CCs administer YSS on the other two 90 day administrations that do not coincide with longitudinal study interviews
	No	No		CCs administer YSS every 6 months of enrollment at the end of TRAC interview
	Yes	No		Interviewers administer YSS (and TRAC)
		Longitudinal study enrolled?	CBAY enrolled?	YSS Administration Schedule
Expansion	--	Yes		CCs administer YSS every 90 days from date of enrollment
	--	No		CCs administer YSS semi-annually on the fiscal year November 15 (close Dec. 31) and May 15 (close June 30)
Note. All families receive the YSS at discharge.				

YSS administrations that are timed with respect to enrollment dates (i.e., 90 days from enrollment, 6 months from enrollment) are distributed 1 month prior to the due date. Care Coordinators will receive email notification YSS due dates as appropriate. Please see the YSS Administration Instructions for more details



Referral Process

■ Referral Form submitted to WIN GA.

Referral Source:

- Child/Family Self Referral
- Juvenile Justice
- Juvenile Court
- Family and Children Services
- Mental Health
- Public Health
- Education System
- Local Interagency Planning Team

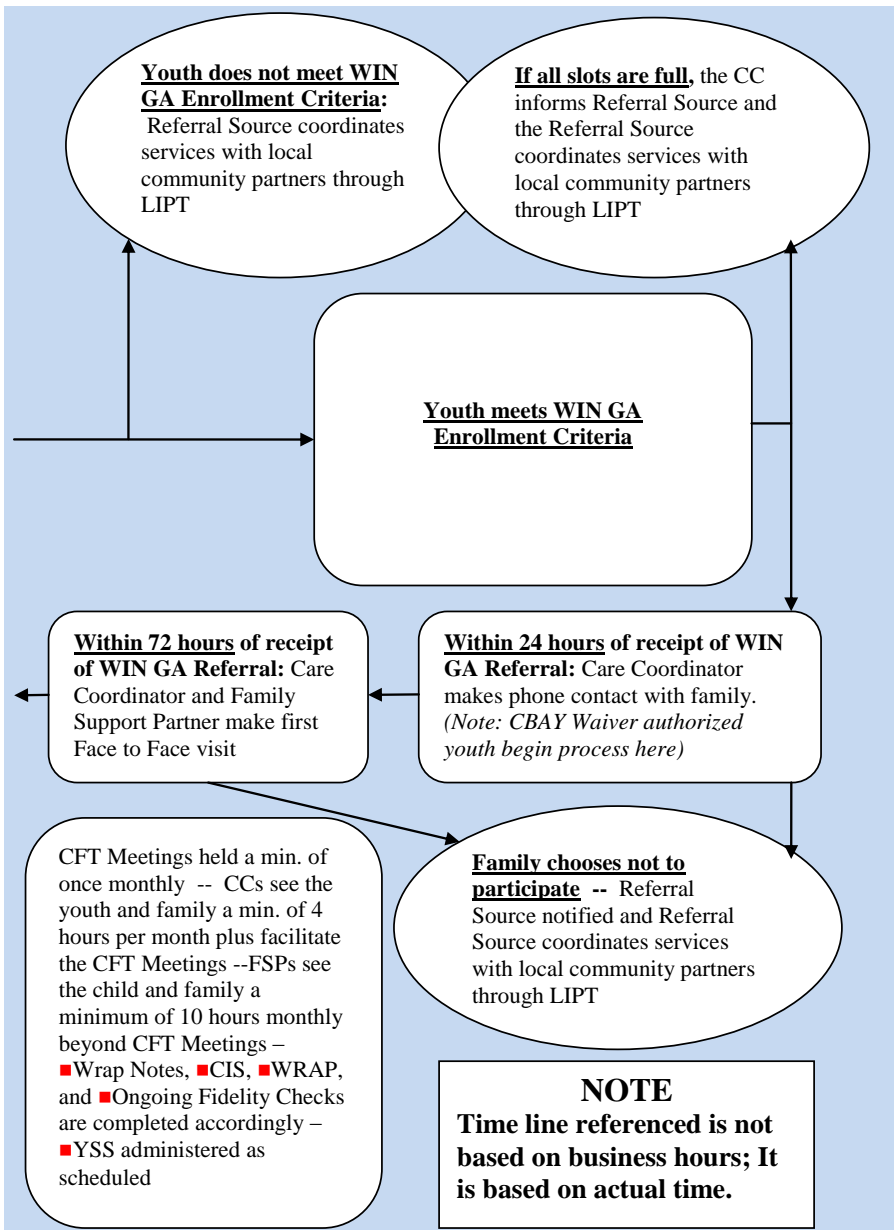
Youth receives Mental Health Assessment by Core or Private Provider if youth has not had an Assessment in the last 12 months. CC completed ■ Non-Waiver Enrollment Criteria Form.

Family chooses to participate: During first Face-to-Face: ■ ROI, ■ Crisis/Safety Plan, ■ Wraparound Intake, and ■ CIS are completed -- CFT Members Identified -- Date/Times for Child & Family Team Meeting discussed -- Inform family additional Face-to-Face Meetings may take place with the Care Coordinator prior to the Child & Family Team Meeting, if needed.

Clock starts for evaluation data collection: YSS, TRAC, Longitudinal Study

Care Coordinator contacts identified CFT Members and schedules First CFT Meeting. First CFT Meeting held **within 14 days** of receipt of the WIN GA Referral

At first CFT Meeting: ■ WRAP and ■ First Fidelity Check are complete; National Evaluation introduced in SAMHSA counties





WIN GEORGIA WRAPAROUND REFERRAL FORM

Please complete and email to address below

DATE: _____

Youth's Name: _____

DOB: _____

Age: _____

Gender: _____

Race: _____

Parent/Guardian's Name: _____

Address: _____

City: _____

Zip: _____

Youth/Family Phone Number: _____

County: _____

Referring Agency:

<input type="checkbox"/> Parent/Guardian	<input type="checkbox"/> Mental Health Core Provider (DBH)	<input type="checkbox"/> DFCS
<input type="checkbox"/> Inpatient Hospital	<input type="checkbox"/> Private MH Provider	<input type="checkbox"/> Law Enforcement
<input type="checkbox"/> Crisis Stabilization Program (CSP)	<input type="checkbox"/> DJJ	<input type="checkbox"/> School
<input type="checkbox"/> Residential Facility/Provider	<input type="checkbox"/> Juvenile Court	<input type="checkbox"/> Other: _____

Person Referring: _____

Email: _____

Phone Number: _____

Fax Number: _____

Other Agencies Currently Involved:

<input type="checkbox"/> School	<input type="checkbox"/> Mental Health Core Provider (DBH)	<input type="checkbox"/> DFCS
<input type="checkbox"/> Inpatient Hospital	<input type="checkbox"/> Private MH Provider	<input type="checkbox"/> Law Enforcement
<input type="checkbox"/> Crisis Stabilization Program (CSP)	<input type="checkbox"/> Juvenile Court	<input type="checkbox"/> Other:
<input type="checkbox"/> Residential Facility/Provider	<input type="checkbox"/> DJJ	

School Attending: _____

Current Grade: _____

Special School Services (if applicable): _____

MH Diagnosis (if applicable): _____

AOD Diagnosis (if applicable): _____

CAFAS Score: _____

Medications (if applicable): _____

What are the youth and/or family's strengths? _____

Presenting Problems? _____

Ever been staffed at LIPT? Yes No

If Yes, LIPT Decision: _____

Thank you for your referral to High-Fidelity Wraparound.
We will review this referral and contact you in three business days.

Send Completed Referral Form to:

Email:

Fax:

Wraparound Referral Form

- All referral forms are submitted via email, either by an outside referring party or local project assistant (for referrals phoned in)
- All referrals are automatically forwarded electronically to the Care Coordinators who determine if youth referred meet Non-waiver Criteria (*instructions on following page*).
- Referral forms emailed/faxed to Database Manager immediately upon receipt
- When a parent, behavioral health provider or child-serving agency partner makes a referral, the items on the referral form need to be filled out completely. For items left blank, the CC should call the referring party and either ask for the needed information or for a new, completed form.

New in Version 1.2: Race has been added to the demographic information section.



WRAPAROUND
NON-WAIVER ENROLLMENT CRITERIA



Youth's Name: _____ DOB: _____

Date of Referral: _____

- Mental Health Diagnosis (1 pt)
- Substance Abuse Diagnosis (1 pt)

Please select all applicable emergent needs (1 pt each)

- Self Harm Sexual Offense Fire Setting/Property Destruction Runaway
- Active Substance Abuse Other – Please specify: _____

- Juvenile Justice Involvement (1 pt)
- Child Welfare Involvement (1 pt)

Youth's functioning as determined by the CAFAS:

- CAFAS: 90 – 100 (1pt)
- CAFAS: 110 (2 pts)
- CAFAS: 120 (3 pts)
- CAFAS: 130 (4 pts)
- CAFAS: ≥ 140 (5 pts) – Please ask Core Provider for CBAY Referral

Total Score: _____

Enrollment Criteria Scoring:

- ≥ 7 pts Staff may contact family and offer Wraparound services
- < 7 pts Does not meet criteria for Wraparound; follow-up with referring party

Disposition: Parent Accepted Did Not Meet Criteria
 Parent Refused Met Criteria but No Space Available

If either of the above selected, where was the youth referred?



Non-Waiver Enrollment Criteria

- Non-Waiver Criteria form is used to assist the CME in determining if a youth is potentially at high-risk of out-of-home placement
- The form is completed and score calculated by the Care Coordinator
- With a score of 7 or higher and available space:
 - Care Coordinator contacts the family and offers Wrap-around
 - The family's decision is then recorded on the Non-waiver Criteria form
 - The Care Coordinator then contacts referring party with family's decision
- With a score of 6 or lower:
 - Care Coordinator contacts the referring party and recommends other community options, per the form's instructions
 - The disposition is then recorded on the Non-waiver Criteria form

CLARIFICATION POINTS:

- Please get approval from CME management before using comparable assessment data (e.g., GAF, CANS). If criteria is met via comparable assessment information, please file a copy of the assessment in the youth's Wraparound Record



Unified Release of Information

Wraparound Initiative Northwest Georgia



Date: _____

Case#: _____

Youth's Name: _____

Date of Birth: _____

Section A1: Use or Disclosure of Health/Education Information

By signing this form, I authorize the disclosure of my individually-identifiable health/education information by the following:

- Juvenile Court
- Department of Juvenile Justice
- Department of Family and Children Services
- Mental Health Provider(s) (specify): _____
- _____
- School(s) (specify): _____
- Wraparound Initiative Northwest Georgia (WIN GA)
- WIN GA Evaluation Team
- Any other organization providing services to you and your family
- Other _____

Section A2: Use or Disclosure of Health/Education Information

By signing this form, I authorize the disclosure of my individually-identifiable health/education information to the following:

- Juvenile Court
- Department of Juvenile Justice
- Department of Family and Children Services
- Mental Health Provider(s) (specify): _____
- _____
- School(s) (specify): _____
- Wraparound Initiative Northwest Georgia (WIN GA)
- WIN GA Evaluation Team
- Any other organization providing services to you and your family
- Other _____

Section B: Scope & Use of Disclosure

Information that may be used or disclosed based on this authorization is as follows (check one):

- All health information about me, including medical records created or received by the Provider. This information may include, if applicable:
 - Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse, mental health disorders, educational issues/needs, legal issues/needs and/or social/recreational issues/needs.
 - Services provided by the above agencies during the period of this release
 - Services provided by the above agencies prior to this release
 - Information concerning the testing for HIV (Human Immune Virus) and/or treatment for AIDS (Acquired Immune Deficiency Syndrome) and any related conditions.
 - Privileged communications between me and a psychiatrist, psychologist, licensed marriage & family counselor, or licensed professional counselor or between them concerning my communications with them.
- All health information about me as described in the preceding checkbox, excluding the following: _____

- Specific health information including only the following: _____

- All education information about me, including education records. This information may include, if applicable: report cards, attendance, discipline, IEP, 504 plan, evaluation

Section C: Purpose of Use or Disclosure

The purpose for this disclosure is (check one):

- Specifically, the following _____
- The youth chooses not to disclose the purpose. NOTE: This box may NOT be checked if the information to be disclosed pertains to alcohol or drug abuse information.

Section D: Expiration

NOTE: If an expiration event is used, the event must relate to the youth or the purpose for the disclosure

Event _____ Consent
for Release of Health Information expires 12 months from the date it was signed. Consent for Health Information must last no longer than "reasonably necessary to serve the purpose for which consent is given". 42 CFR 2.31 (a)(9)

Section E: Other Important Information

1. I understand that the System of Care agencies cannot guarantee that the recipient will not disclose this information to a third party. The recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of further information about a youth in an alcohol or drug abuse program, the recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the consumer or as otherwise permitted by federal law governing confidentiality of alcohol and drug abuse patient records (42 CFR, Part 2).
2. I understand that, except when I am receiving health care solely for the purpose of creating information for disclosure to a third party, I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain services.
3. I understand that I may revoke this authorization in writing at any time, except that the revocation will not have any effect on any action taken by the System of Care in reliance on this authorization before written notice of revocation is received.
4. I understand that educational records are confidential under state and federal law and by signing this Unified Release of Information; I am authorizing the release of educational records.

Date	Signature of Youth
Date	Signature of Parent/Legal Guardian
Date	Signature of Witness (Title):

Unified Release of Information

Explain the following to caregiver and youth (11 or older):

- *We believe that we can provide better services for your child if systems and providers can share information.*
- *Several laws prevent us from sharing information unless you approve.*
- *The form allows systems and providers to share information only for the purposes of Wraparound service delivery and evaluation*
- *All sharing of information will be governed by legal and ethical guidelines that assure your confidentiality is maintained*
- *EMSTAR Research evaluates the quality and cost-effectiveness of Wraparound services. Your child/family will not be identified in any reports or research published by EMSTAR.*
- *You may cancel or revoke the authorization at any time. You may limit the authorization's time frame at any time.*
- *We will give you a copy of the Authorization.*

Give caregivers the form and make yourself available for questions.

A completed ROI form should have the following:

1. Youth's name, DOB, and date
2. Check marks next to all agencies you authorize sharing BY (checks in all boxes is desired)
3. Check marks next to all agencies you authorize sharing TO (checks in all boxes is desired). Names of specific MH providers and schools
4. Check marks next to each type of information authorized to be shared (all health and all education is desired)
5. A stated purpose of the release (e.g., "Wraparound service planning, implementation, and evaluation")
6. Caregiver signature and date (for youth younger than 18)
7. Signature and date for youth (11 or older)
8. Signature and date of witness



Unified Safety and Crisis Plan

- The Unified Crisis and Safety Plan is to be completed at the first Family Engagement Meeting along with the Strengths Discovery by the family, Care Coordinator, and Family Support Partner
- The Unified Crisis and Safety Plan is subsequently reviewed and revised at every Child & Family Team Meeting (CFT)
- Please know that the Crisis and Safety plan sections can be completed separately per the family's need, and is recorded separately on the First Fidelity Check
- Please file the completed plan in the Wraparound Record

CLARIFICATION POINTS:

- Always address safety planning before crisis planning
- "Grade" is the youth's grade in which they are currently enrolled. During the summer break, please use the grade the youth will be enrolled in on the first day of the new school year
- "Support's Name" include all child-serving agency partners, behavioral health providers, and others who will provide supports and services to the family during a crisis



Wraparound Intake Form



Name of person completing form _____
First name *Last name*

Date completed ____ / ____ / ____
mm *dd* *yy*

Sources of information used to complete this form (select all that apply):

- Caregiver
- Staff as Caregiver
- Youth
- Case record review
- Other

Agency(s) that youth is currently involved with (select all that apply):

- Adult Corrections
- Adult Probation
- Juvenile Court
- DJJ
- School
- Mental Health Provider
- Medical Provider
- Child Welfare
- Substance Abuse Tx Provider
- Family Court
- Early Care: Early Head Start program
- Early Care: Head Start program
- Early Care: Early Intervention (Part C)
- Early Care: Other early care/education program
- Other (specify): _____
- Not currently involved with any services

IF 'Child Welfare' selected above -- Type of Child welfare involvement

- Receiving youth abuse and neglect investigation
- Court-ordered out-of-home placement (foster, relative, residential)
- Voluntary out-of-home placement (foster, relative, residential)
- Court-ordered in-home services (i.e., Family Preservation)
- Voluntary in-home services (i.e., Family Preservation)

Agency or individual who referred youth to the program (select all that apply):

- Adult Corrections
- Adult Probation
- Juvenile Court
- DJJ
- School
- Mental Health Provider
- Medical Provider
- Child Welfare
- Substance Abuse Tx Provider
- Family Court
- Caregiver
- Youth
- Early Care: Early Head Start program
- Early Care: Head Start program
- Early Care: Early Intervention (i.e., Babies Can't Wait)
- Early Care: Other early care/education program
- Other (specify): _____

Youth's Legal Name _____
First *Middle* *Last*

Name youth goes by (if different): _____ Date of Birth ____ / ____ / ____
mm *dd* *yy*

County of residence _____ Zip code of residence _____

County in which youth is receiving services (if different from county of residence) _____



Wraparound Intake Information

Page One

- Wraparound Intake Information (WII) is completed during the second Family Engagement Meeting
- This information is collected one time and used as baseline information
- It should be entered into database within 2 business days of meeting

CLARIFICATION POINTS:

- Child Welfare is a department within DFCS. DFCS houses financial support services such as TANF and child welfare (e.g., CPS). Only mark this selection if youth and family are involved with child welfare side of DFCS. Financial support services information is collected on the next page
- All private and core providers are recorded as Mental Health Provider
- “County in which youth is receiving services” refers to the county where service operations originate. For instance, a youth living in Cherokee County may have a CME service provider operating from Bartow County.



Gender: Male Female Transgender

Is youth Hispanic or Latino? Yes No

IF 'Yes' – **Which group describes youth's background?**

- Mexican, Mexican American, or Chicano Central American
- Puerto Rican South American
- Cuban Other (specify): _____
- Dominican

Race (select all that apply):

- American Indian White
- Alaska Native Native Hawaiian, Pacific Islander
- Asian Other (specify): _____
- Black or African American

Youth lives with (select all that apply):

- Biological mother Grandmother
- Stepmother Grandfather
- Foster mother Sister (How many? ____)
- Biological father Brother (How many? ____)
- Stepfather Child Caring Institute (e.g., Long-term respite, Group home)
- Foster father Other (specify): _____

Legal Custodian: Place a 'C' to the right of the individual(s) above that is the youth's legal custodian.

(Indicate more than one custodian if necessary.) If youth is in state custody check here

During the past 6 months has the youth received (select all that apply):

- Medicaid (select type below) SSDI
 - APS Healthcare SSI
 - Peachstate (Cenpatico) Childcare Assistance Program (CAPS)
 - Wellcare (Magellan) TANF
 - Amerigroup Food stamps
- State Contracted Services Section 8 Housing
- Private insurance (specify): _____ Other (specify): _____
- Family will self pay for services



Wraparound Intake Information

Page Two

CLARIFICATION POINTS:

- “Transgender” is a youth who is biologically one gender, yet acknowledges the desire and lives as the opposite gender
- Be sure to write in a “C” to indicate legal custody to all that apply
- Financial support information should be recorded as follows:
 - SSDI - Youth receives
 - SSI - Youth receives
 - CAPS - Youth and family receives
 - TANF - Youth and family receives
 - Food stamps - Youth and family receives
 - Section 8 - Youth and family receives
- “Family will self pay for services” does not apply to youth and family being billed for Wraparound, but rather indicates family self pays for clinical services.



What are the problems leading to the youth being referred? (select all that apply):

- Depression-related problems (including major depression, dysthymia, sleep disorders, somatic complaints)
- Anxiety-related problems (including phobias, generalized anxiety, social avoidance, obsessive-compulsive, post-traumatic stress disorder)
- Hyperactive and attention-related problems (including hyperactive, impulsive, attention deficit disorder)
- Adjustment-related problems (including changes in behaviors or emotions in reaction to a significant life stress)
- Psychotic behaviors (including hallucinations, delusions, strange or odd behaviors)
- Eating disorder (including anorexia, bulimia)
- Substance use, abuse, and dependence
- Physical aggression
- Extreme verbal abuse
- Sexual acting out
- Risky sexual behavior (e.g., unprotected sex, multiple partners, substance use with sex)
- Sexual assault (by youth in question)
- Sleeping problems
- Gender identity
- Running away
- Theft
- Property damage
- Fire setting
- Cruelty to animals
- Truancy
- Police contact
- Suicide attempt
- Suicidal ideation
- Self-injury
- Threat to life of others (including homicidal ideation, threats, attempts)
- Academic problems (not learning disability)
- Learning disability
- Expressive or receptive speech problems or language delay
- Pervasive developmental disabilities (including autistic behaviors, extreme social avoidance, attachment disorder, stereotyped or perseverative behavior)
- *Feeding problems in young children (including failure to thrive)*
- *Disruptive behaviors in young children (including aggression, severe defiance, acting out, impulsivity, recklessness, and excessive level of overactivity)*
- *Persistent noncompliance (when directed by adults)*
- *Excessive crying/tantrums*
- *Separation problems*
- *Non-engagement with people*
- *Excluded from preschool or childcare due to behavior problems, noncompliance*
- At risk or has failed family home placement
- Maltreatment (victim of abuse or neglect)
- Medical problem (illness or disease)
- Enuresis
- Encopresis
- High risk environment: Maternal depression
- High risk environment: Maternal mental health (not depression)
- High risk environment: Paternal mental health
- High risk environment: Caregiver mental health (not mother or father)
- High risk environment: Maternal substance abuse
- High risk environment: Paternal substance abuse
- High risk environment: Caregiver substance abuse (not mother or father)
- High risk environment: Family health problems (maternal, paternal, caregiver, or other family member)
- High risk environment: Other parent/caregiver/family problems
- High risk environment: Housing problems (including homelessness)
- High risk environment: Financial strain (not enough money)
- High risk environment: History of domestic violence in the household
- High risk environment: History of child maltreatment in the household
- Other problems (specify): _____

Wraparound Intake Information

Page Three

- If you have any question or concerns, please contact your Wraparound Supervisor



Wraparound Intake Information

Page Four

CLARIFICATION POINTS:

- Enrolled in regular education is not considered “school-based services.” Only mark this item for special education, section 504 or SST services
- “Residential Treatment” refers to both PRTF (Psychiatric Residential Treatment Facility) and CCI (Child Caring Institute)
- “Other” refers to services such as CSP, Therapeutic Home Care, etc.
- If youth is on probation with an independent court, please select “probation” rather than “court services”
- “Does youth have a DSM diagnosis?” If this is marked “no,” please skip to Family Information; however, contact Wraparound Supervisor immediately regarding the appropriateness of providing Wraparound



DSM Axis IV – Psychosocial and Environmental Problems (select all that apply):

- Problems with primary support group
- Problems related to the social environment
- Educational problems
- Occupational problems
- Housing problems
- Economic problems
- Problems with access to health care services
- Problems related to interaction with the legal system/crime
- Other psychosocial and environmental problems

Axis V: Global Assessment of Functioning Scale (GAF) – Current score = _____

OR mGAF – Current Score = _____

Family Information

Does any parent/caregiver have a criminal conviction? Yes No

Is any parent/caregiver deceased? Yes No

What is the highest level of education completed by any of the youth's caregivers?

- Some High School
- High School Graduate
- Some College
- Associate's Degree
- Bachelor's Degree
- Master's Degree
- Doctoral Degree (MD, PhD, JD)
- No High School completed

Is the youth's female caregiver employed (includes bio-, step-, and foster mothers)? Yes No N/A

If 'Yes' -- How many hours of work in the average week? _____

Is the youth's male caregiver employed (includes bio-, step-, and foster fathers)? Yes No N/A

If 'Yes' -- How many hours of work in the average week? _____

NOTE: For Caregiver Employment, only select N/A if Caregiver is a student, incarcerated, retired or disabled, or if the female or male caregiver is not involved.

What is the annual household income of the youth's family?

(Pre-tax income for family with whom youth has lived for the majority of the past 6 months)

- Less than \$5,000
- \$5,000-\$9,999
- \$10,000-\$14,999
- \$15,000-\$19,999
- \$20,000-\$24,999
- \$25,000-\$34,999
- \$35,000-\$49,999
- \$50,000-\$74,999
- \$75,000-\$99,999
- \$100,000 or more

Has the youth's family moved in the past 6 months? Yes No

Wraparound Intake Information

Page Five

- If you have any questions or concerns, please contact your Wraparound Supervisor



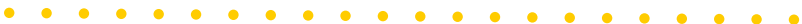
Columbia Impairment Scale (CIS)

Completed by Caregivers

- The Columbia Impairment Scale (CIS) allows a family the opportunity to self-assess how they believe their youth is currently functioning
- The Care Coordinator assists the parent/guardian in completing the CIS at the first or second face-to-face meeting and before every monthly Child & Family Team Meeting (CFT)
- Please know that families are highly encouraged to complete the CIS, but are not required. If a family declines, please reassure that the CIS is an excellent opportunity for a family to personally assess how they believe their youth is doing
- Once completed, please enter CIS into database by the end of the month

The following instructions apply to the administration of this form:

1. Select the caregiver who spends the most time with the youth or is most familiar with the youth's behavior.
2. Have the caregiver complete the form during a scheduled meeting at which the youth is not present.
3. Explain to the caregiver:
 - *We are asking you to complete this form so that we can identify improvements resulting from Wraparound services and help improve our services.*
 - *Completing the form should take 5-10 minutes.*
 - *Your responses are completely confidential, meaning the individual information you provide will not be shared with anyone. It will be grouped with responses from all other recipients of Wraparound services and reported as a whole.*
 - *You can skip any item you are not comfortable answering*
4. Finally, thank the caregiver for sharing their perspective.



FAMILY WRAPAROUND ACTION PLAN



Service Site (County): _____

Wraparound w/ CBAY Wraparound w/ DFCS (FTM Only) Wraparound

Youth's Name:	Last Name First Name		DOB: / / mm dd yy	
Home Address:	Street		City	Zip County
Wrap Start Date:	Meeting Date:		Meeting Location:	
Meeting Type:	<input type="checkbox"/> Initial	<input type="checkbox"/> Ongoing	<input type="checkbox"/> Transition	

If Transition, reason for discharge:	<input type="checkbox"/> Youth aged out of service	<input type="checkbox"/> Family moved out of community	<input type="checkbox"/> Youth/family not engaged	<input type="checkbox"/> Youth withdrawn by caregiver	<input type="checkbox"/> Long-term commitment	<input type="checkbox"/> Successful discharge	<input type="checkbox"/> Other:
---	--	--	---	---	---	---	---------------------------------

FAMILY VISION - TO BE WRITTEN IN FAMILY'S VOICE

TEAM MISSION

STRENGTHS DISCOVERY

YOUTH'S STRENGTHS:

FAMILY'S STRENGTHS:

TEAM'S STRENGTHS:

CHALLENGES & BARRIERS

YOUTH'S CHALLENGES:



Wraparound Action Plan

Page One

ACTION PLAN GUIDELINES:

- Care Coordinator completes and enters the Action Plan into the database within 24 hours of Child & Family Team Meeting (CFT)
- Strategic family plan and Part A are completed with every plan; however, Part B is not required for the initial Action Plan (See Action Plan page 7 instructions for Part B guidelines)
- CBAY ONLY: Wraparound Supervisor emails reviewed Action Plan to CBAY office for authorization
- Action Plan information may be completed prior to Child & Family Team Meeting (CFT)

CLARIFICATION POINTS:

- Please select which Action Plan is being completed:
 1. Wraparound w/ CBAY are youth authorized for CBAY services
 2. Wraparound w/ DFCS (FTM) refers to families who also qualify for FTM services through DFCS. (NOTE: Please offer to families the option of combining the Child & Family Team Meeting (CFT) with DFCS Family Team Meeting (FTM) so as to avoid families attending multiple meetings and duplication)
 3. Wraparound refers to all other families who have qualified and accepted Wraparound
- “Transition” selection is marked for the final Child & Family Team Meeting (CFT). Transition is used only when family is transitioning out of Wraparound
- **New in Version 1.2:** Reason for Discharge selected if meeting type is Transition.

ACTION PLAN NOTES

Who Attended Wraparound Team Meeting (CFT)?

NATURAL SUPPORTS

- Mother Father Sibling
- Grandparent Family Relative
- Family Friend Youth's Friend
- Neighbor Other(s):

INFORMAL SUPPORTS

- Church Pastor Mentor
- Rec. Coach Store Mngr
- Tutor Agency Personnel
- Activities Staff (e.g., Scouts, etc.)
- Other(s): _____

FORMAL SUPPORTS

- Teacher School SW/Counselor
- Prob. Off. DFCS Staff VR
- MH Therapist AD Counselor
- CC FSP Wrap Supervisor
- Physical Health Other(s):

FAMILY STRATEGIC PLAN

YOUTH/FAMILY NEEDS STATEMENT #1:

Expected Outcome:

a. Strategy/Intervention:	
i. Deadline:	
ii. Name and # of person responsible:	
b. Strategy/Intervention:	
i. Deadline:	
ii. Name and # of person responsible:	
c. Strategy/Intervention:	
i. Deadline:	
ii. Name and # of person responsible:	
d. Strategy/Intervention:	
i. Deadline:	
ii. Name and # of person responsible:	

YOUTH/FAMILY NEEDS STATEMENT #2:

Expected Outcome:

a. Strategy/Intervention:	
i. Deadline:	
ii. Name and # of person responsible:	
b. Strategy/Intervention:	
i. Deadline:	
ii. Name and # of person responsible:	
c. Strategy/Intervention:	
i. Deadline:	
ii. Name and # of person responsible:	
d. Strategy/Intervention:	
i. Deadline:	
ii. Name and # of person responsible:	



Wraparound Action Plan

Page Two

- If you have any question or concerns, please contact your Wraparound Supervisor



YOUTH/FAMILY NEEDS STATEMENT #3:

Expected Outcome:	
a. Strategy/Intervention:	
i. Deadline:	
ii. Name and # of person responsible:	
b. Strategy/Intervention:	
i. Deadline:	
ii. Name and # of person responsible:	
c. Strategy/Intervention:	
i. Deadline:	
ii. Name and # of person responsible:	
d. Strategy/Intervention:	
i. Deadline:	
ii. Name and # of person responsible:	

LIFE DOMAINS ADDRESSED (Please select all that apply)

- FAMILY
 HOUSING
 SOCIAL
 EDUCATIONAL
 VOCATIONAL
 MEDICAL
 COMMUNITY
 EMOTIONAL/BEHAVIORAL
 SAFETY

WRAPAROUND ACTION PLAN SIGNATURES

Parent/Guardian’s signature: _____ Date _____

Youth’s signature (if applicable): _____ Date _____

Family Support Partner signature: _____

Care Coordinator signature: _____

Team Member signature: _____

Team Member signature: _____

Team Member signature: _____

Team Member signature: _____



Wraparound Action Plan

Page Three

- Although Care Coordinator may create the Action Plan after Child & Family Team Meeting (CFT), the signature page should be signed while at the meeting
- Once Action Plan is reviewed and approved by either Wrap-around Supervisor or CBAY office, pages 1 – 3 are copied and presented to family and all other team members
- If you have any question or concerns, please contact your Wraparound Supervisor



Wraparound Action Plan

Page Four

CLARIFICATION POINTS:

- PART A (pages 4 & 5) record which services and/or supports are being received and recommended
- PART A must be completed after all Child & Family Team Meeting and submitted to CBAY office, if applicable
- PART A may also be presented to family upon request
- “SERVICES/SUPPORTS RECEIVED” section is completed for all services and/or supports received during the past month
- “Needs Statement” is completed according to which Needs Statement in the Strategic Plan applies to the service and/or support received
- If you have any question or concerns, please contact your Wraparound Supervisor



Wraparound Action Plan

Page Five

CLARIFICATION POINTS:

- “Services Unavailable” refers to services that were recommended during the previous month’s Child & Family Team Meeting , but were not available. This should be reported to the Local Interagency Planning Team (LIPT) as these teams are recording gaps in service array
- “SERVICES/SUPPORTS RECOMMENDED” section is completed for all services and/or supports recommended during the past month
- “Needs Statement” is completed according to which Needs Statement in the Strategic Plan applies to the service and/or support received
- If you have any question or concerns, please contact your Wraparound Supervisor



Informal Supports (Name) (e.g., Pastor, Mentor, Manager, etc.)	Frequency	Relationship to Family	Date of First Appt	Needs Statement
Formal Supports (e.g., Child-serving agencies, etc.)	Frequency	Relationship to Family	Date of First Appt	Needs Statement
Parenting Support & Training (Classes)				
Therapeutic Home Care (Respite)				
School-based Tutoring				
Supported Employment (e.g., Voc Rehab)				
After School Program (On Campus)				
Agency Funded Mentoring Program				
Reporting Centers (e.g., ERC)				
CASA				
Other (please specify):				
MRO (Therapy) Services <input type="checkbox"/> None	Therapeutic Provider		Authorization Period	Needs Statement
Individual Therapy <input type="checkbox"/> MH <input type="checkbox"/> AD				
Family Therapy <input type="checkbox"/> MH <input type="checkbox"/> AD				
Group Therapy <input type="checkbox"/> MH <input type="checkbox"/> AD				
Diagnostic Assessment				
Nursing Assessment				
Psychiatric Services				
Community Support Individual				
Intensive Family Intervention				
Medication Management				
Behavioral Assistance				
Community Transition				
Out-of-clinic Crisis				
CBAY SERVICES (if applicable) <input type="checkbox"/> None	CBAY Provider		Date of First Appt	Needs Statement
Family Support & Training				
Clinical Consultative & Counseling				
Respite (Therapeutic Home Care)				
Supported Employment				
Customized Goods & Services				
Community Transition Services				
Community Guide Services				
Unskilled Wraparound				
Transportation				



Wraparound Action Plan

Page Six

CLARIFICATION POINTS:

- “Needs Statement” is completed according to which Needs Statement in the Strategic Plan applies to the service and/or support received
- If you have any question or concerns, please contact your Wraparound Supervisor



PART B – Information section is not required for the first Wraparound Team Meeting (CFT)

I. CHILD-SERVING AGENCY INFORMATION

Agencies and/or programs involved in the past month: (check all that apply): <input type="checkbox"/> None	<input type="checkbox"/> DFCS <input type="checkbox"/> DJJ <input type="checkbox"/> Juvenile Court <input type="checkbox"/> Private MH/AD Provider <input type="checkbox"/> MH/AD Core Provider	<input type="checkbox"/> CSP [# of admissions ____] <input type="checkbox"/> Inpatient Hospital [# of admissions ____] <input type="checkbox"/> CCI (billing RBWO) <input type="checkbox"/> PRTF: _____ <input type="checkbox"/> Other: _____
	Current DJJ Disposition: <input type="checkbox"/> None	<input type="checkbox"/> Probation (DJJ) <input type="checkbox"/> Informal Adjustment <input type="checkbox"/> Drug Court <input type="checkbox"/> MH Court <input type="checkbox"/> Probation (Court) <input type="checkbox"/> Committed (in community) <input type="checkbox"/> Committed (out of community) <input type="checkbox"/> RYDC [# of days detained ____] <input type="checkbox"/> STP [# of days detained ____]

Next Court Date (if applicable): mm / dd / yy	Presiding Judge:
--	-------------------------

School Enrollment: <input type="checkbox"/> Public School <input type="checkbox"/> Private School <input type="checkbox"/> GED <input type="checkbox"/> Home School <input type="checkbox"/> Graduated <input type="checkbox"/> Expelled (will return) <input type="checkbox"/> Student Disenrolled	If Enrolled Select Location: <input type="checkbox"/> Mainstream <input type="checkbox"/> Alternative <input type="checkbox"/> GNET <input type="checkbox"/> Homebound <input type="checkbox"/> Other _____	Enrollment Type: <input type="checkbox"/> Regular Ed. <input type="checkbox"/> Regular Ed. w/ SST or 504 Plan <input type="checkbox"/> Special Ed.	Special Ed. Eligibility (if applicable): <input type="checkbox"/> Emotional Behavior Disorder (EBD) <input type="checkbox"/> Other Health Impaired (OHI) <input type="checkbox"/> Mild Intellectual Disability (MID) <input type="checkbox"/> Specific Learning Disorder (SLD) <input type="checkbox"/> Other _____
---	---	--	---

DFCS Services: <input type="checkbox"/> Financial Supports <input type="checkbox"/> Investigations <input type="checkbox"/> Family Preservation <input type="checkbox"/> Foster Care <input type="checkbox"/> None	If in State Custody (Foster Care): Care Plan Type: <input type="checkbox"/> Reunification <input type="checkbox"/> Non Reunification (TPR) How many times did youth's placement change this month? ____	Family Stability: Is caregiver employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A Is youth employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A How many times has the family moved this month? ____
--	---	--

DFCS Was combining CFT & FTM offered to the family as an option? Yes No
FTM If no, please explain: _____
USE Were the same participants requested by family invited to CFT/FTM? Yes No
ONLY: If no, please explain: _____

During the past 6 months has the youth received (select all that apply):

- Medicaid (select one type below)
 - APS Healthcare
 - Peachstate (Cenpatico)
 - Wellcare (Magellan)
 - Amerigroup
- State Contracted Services (SCS)
- Private insurance (specify): _____
- SSDI
- SSI
- Childcare Assistance Program (CAPS)
- TANF
- Food stamps
- Section 8 Housing
- Other (specify): _____

Youth lives with (select all that apply):

- Biological Mother
- Stepmother
- Foster Mother
- Biological Father
- Stepfather
- Foster Father
- Grandmother
- Grandfather
- Sister (How many? ____)
- Brother (How many? ____)
- Child Caring Institute (e.g., Long-term respite, Group home)
- Other (specify): _____

Legal Custodian: Place a 'C' to the right of the individual(s) above that is the youth's legal custodian. (Indicate more than one custodian if necessary.) If youth is in state custody check here

Wraparound Action Plan

Page Seven

PART B ACTION PLAN GUIDELINES:

- PART B is not required for the initial Action Plan because this information is captured at the second Family Engagement Meeting via the Wraparound Intake Information (WII)
- CBAY: PART B should be submitted along with the family strategic plan and Part A to CBAY office for authorization
- Non-waiver: PART B should be submitted along with the family strategic plan and Part A to Wraparound Supervisor for review .
- PART B should be entered into the database within 24 hours of CFT

CLARIFICATION POINTS:

- For any questions regarding acronyms, please contact the Wraparound Supervisor
- For any questions regarding program terms, please contact the Wraparound Supervisor. The following are commonly misunderstood program terms:
 - “Informal Adjustment” is a court diversion program
 - “Student Disenrolled” is a student drop-out
 - “Homebound” is enrolled Hospital Homebound
 - “GNET” is formally called Psychoeducational
 - “DFCS Financial Supports” e.g., TANF, Food Stamps
- “DFCS FTM Use Only” is completed when Child & Family Team Meeting (CFT) and Family Team Meeting (FTM) are being combined
- For instructions on how to complete financial, insurance and custody information, please see Wraparound Intake Information instructions

Wraparound Action Plan

Page Eight

- For instructions on how to complete Health and Diagnostic Information, please see Wraparound Intake Information instructions
- If you have any question or concerns, please contact your Wraparound Supervisor



First Fidelity Check

Youth Name _____ DOB _____ County _____

CBAY ONLY: Date Authorization Received: _____ First Contact Date: _____ Was first contact w/in 48 hours? Y N

NON-WAIVER ONLY: Was family offered Wraparound w/in 48 hours of meeting criteria? Y N Start Date: _____

Assigned Care Coordinator _____ Assigned Family Support Partner _____

First Family Engagement Meeting Date: _____ Who attended? CC FSP Did the family choose the meeting location? Y N

Was there a family-created vision statement? Y N What was accomplished? Strengths List Crisis Plan Safety Plan

Was Release of Information (ROI) discussed with family and signed? Y N

Second Family Engagement Meeting Date: _____ Who attended? CC FSP Did the family choose the meeting location? Y N

Which items were revised from first meeting? Family Vision Statement Strengths List Crisis Plan Safety Plan Nothing Revised

Did family provide dates/times for Wrap Team Meeting? Y N Did family create Wrap Team Meeting participant list? Y N

Was Family Team Meeting Preparation Interview completed? Y N Was the Wraparound Intake Information form started? Y N

For any "N" please explain _____

First Wraparound Team Meeting (CFT) – Wraparound Supervisor should complete the following information after the initial Wraparound Team Meeting

Date of Meeting _____ How many days from Non-Waiver start date or CBAY Authorization? _____

of natural supports attending: _____ # of informal supports attending: _____ # of formal supports attending: _____

How many supports did the youth invite? _____ Did the family choose the meeting location? Y N

Which items were revised from first meetings? Family Vision Statement Strengths List Crisis Plan Safety Plan Nothing Revised

How many challenges were discussed? _____ How many of these challenges were addressed as Needs Statement in the Action Plan? _____

Did the Wraparound Team vote on these? Y N Date Action Plan completed: _____

How many days from CFT was Action Plan submitted to Wrap Supervisor for review? _____ Did Wrap Team receive a copy? Y N

For any "N" please explain _____

Date of next Wraparound Team Meeting: _____ (If none scheduled, write TBA)

Form First Fidelity 10/19/09 rev6



First Fidelity Check

- First Fidelity Check is completed by the Care Coordinator after the initial Child & Family Team Meeting (CFT) and entered into the database within 5 business days of CFT
- This Fidelity Check includes all key elements of the Family Engagement and Child & Family Team Meeting

CLARIFICATION POINTS:

- Release of Information (ROI) should be thoroughly discussed and signed by parent/guardian. For instance, please make sure all “to” and “from” boxes are initialed or checked
- Please inform the family that if “evaluation” box is not initialed or marked, they may receive Wraparound, but will not be part of the overall analysis
- For any “N” (no) responses, please indicate which item was a “no” response, and briefly explain why those items were so marked



Ongoing Fidelity Check

Youth Name _____ DOB _____ County _____

Care Coordinator _____

WEEK TWO

face-to-face contacts (natural supports) _____ # face-to-face contacts (informal supports) _____ # face-to-face contacts (formal supports) _____
 # of phone contacts (natural supports) _____ # of phone contacts (informal supports) _____ # of phone contacts (formal supports) _____
 # of contact that were a crisis _____ Were providers contacted about crises? Y N Did assigned providers respond to each crisis? Y N
 Did assigned providers respond to crises in a timely manner? Y N *[If no, please inform local Community Liaison]*

WEEK TWO

face-to-face contacts (natural supports) _____ # face-to-face contacts (informal supports) _____ # face-to-face contacts (formal supports) _____
 # of phone contacts (natural supports) _____ # of phone contacts (informal supports) _____ # of phone contacts (formal supports) _____
 # of contact that were a crisis _____ Were providers contacted about crises? Y N Did assigned providers respond to each crisis? Y N
 Did assigned providers respond to crises in a timely manner? Y N *[If no, please inform local Community Liaison]*

WEEK THREE

face-to-face contacts (natural supports) _____ # face-to-face contacts (informal supports) _____ # face-to-face contacts (formal supports) _____
 # of phone contacts (natural supports) _____ # of phone contacts (informal supports) _____ # of phone contacts (formal supports) _____
 # of contact that were a crisis _____ Were providers contacted about crises? Y N Did assigned providers respond to each crisis? Y N
 Did assigned providers respond to crises in a timely manner? Y N *[If no, please inform local Community Liaison]*

WEEK FOUR

face-to-face contacts (natural supports) _____ # face-to-face contacts (informal supports) _____ # face-to-face contacts (formal supports) _____
 # of phone contacts (natural supports) _____ # of phone contacts (informal supports) _____ # of phone contacts (formal supports) _____
 # of contact that were a crisis _____ Were providers contacted about crises? Y N Did assigned providers respond to each crisis? Y N
 Did assigned providers respond to crises in a timely manner? Y N *[If no, please inform local Community Liaison]*

WRAP TEAM MEETING (CFT)

of natural supports attending: _____ # of informal supports attending: _____ # of formal supports attending: _____
 Date of Meeting _____ How many supports did the youth invite? _____ Did the family choose the meeting location? Y N
 Which items were revised from first meetings? Family Vision Statement Strengths List Crisis Plan Safety Plan Nothing Revised
 How many challenges were discussed? _____ How many challenges are listed as Needs Statements? _____ Did Wrap Team vote on these? Y N
 Date Action Plan completed: _____ How many days from CFT was Action Plan submitted to Wrap Supervisor? _____
 Did Wrap Team receive a copy? Y N For any "N" please explain _____

Form Ongoing Fidelity Check 10/22/09 rev8



Ongoing Fidelity Check

- Ongoing Fidelity Check is completed by the Care Coordinator on a monthly basis after each Child & Family Team Meeting (CFT)
- The Care Coordinator enters each Ongoing Fidelity Check into the database within 5 business days of Child & Family Team Meeting
- The Ongoing Fidelity Check includes all key elements of weekly practice such as face-to-face contacts and subsequent Child & Family Team Meetings (CFT)

CLARIFICATION POINTS:

- For any “N” (no) responses marked regarding behavioral health providers follow-up, please notify the local Community Liaison so that they can address these network needs and concerns
- For any “N” (no) responses marked for the Child & Family Team Meeting (CFT) section, please indicate which item was a “no” response, and briefly explain why those items were so marked



Wraparound Note



Youth's Name _____ DOB _____

Date of contact _____ Treatment Provider _____

WRAPAROUND SITE

Chatham DeKalb Fulton Gwinnett New/Rock Northwest (County _____)

Start Time _____ End Time _____ Amount of time as Crisis _____ Non-Crisis _____

Face to Face Telephone Email

Location of Contact

Staff Completing Note

- Youth
- Parent/Guardian
- Natural Support _____
- Informal Support _____
- Formal Support _____

- School
- Home
- Community
- Court
- Other: _____

- Family Support Partner
- Care Coordinator
- Wraparound Supervisor
- Other _____

Please confer with all staff involved so that only one note is submitted per contact.

Please write multiple supports in the note's narrative

Service/Support(s) Provided

- Family Engagement (Initial Meetings) Coordination - Specify: _____ Crisis/Emergent Support
- Family Meeting (Follow-up, Preparation) 1. _____ Other _____
- Child and Family Team Meeting 2. _____

	New		F/U		
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Current/Emergent Needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal attempt
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal ideation
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Homicidal attempt
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Homicidal ideation
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Truancy (2 absences/week)
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Failing Academic Grades
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Out of school suspension
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Expulsion
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other need(s) _____
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intoxicated/under the Influence
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Appears psychotic	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Combative/destructive behavior	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High-risk behaviors toward self (e.g. runaway)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High-risk behaviors toward others (e.g. gangs)	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adjudicated - Offense _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance Use - Type _____	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	No emergent needs at this time	

Wraparound Note (Please write on back of note if more space is needed)

Progress Toward Family's Vision: Plan Revision Needed Continue w/ Action Plan Plan Scheduled TBA

Staff Signature _____ Date of Note _____



Wraparound Note

- Wraparound Note is completed by CC for each family contact lasting more than 8 minutes
- Wraparound Note data elements are to be entered into the database within 2 business days of contact
- “Tx Provider” is the current behavioral health provider providing mental health and/or addictive disease services
- “Wraparound Site” is selected by the site/county where the staff are providing Wraparound from and not where the youth and family reside
- For service selected as “Face to Face” or “Telephone” with formal, informal, or natural support, please indicate the specific support in the narrative of the progress note. For example, “meeting with youth, his store manager, his friend at work, and probation officer at youth’s job site for....” The narrative describes which informal (store manager), formal (probation officer), and natural (work friend) supports are involved with planning
- If “Other” is selected under “Current Crisis/ Emergent Needs,” please write out the need in the space provided
- If “Plan Revision Needed” is selected, please notify assigned Care Coordinator so item or issue can be addressed at the next Child & Family Team Meeting (CFT)



Youth Services Survey (YSS)

Youth Services Survey—Family (YSS-F)

Page One

1. There are separate versions of YSS forms for CBAY and non-waiver youth, so staff must first identify whether the youth is enrolled in CBAY or not;
2. For both CBAY and non-waiver youth, there are two versions of the YSS:
 - YSS: Youth version
 - YSS-F: Family/caregiver versionThe family is to choose one version to complete -- only one respondent per family.
3. The CC will provide each family:
 - The appropriate survey. *Note: The youth must be at least 11 years of age to complete the survey. Any adult who completes the survey should have been the child's caregiver for the preceding 3 months.*
 - A stamped envelope addressed to EMSTAR Research.
4. Before giving the survey to the family:
 - Fill in the blank on the first page indicating the county of Wraparound service provision
 - Initial the claim form on the last page.
5. Introduce the survey (see script on following page).
6. On the next visit with the family, remind them to complete the survey.
7. \$5 gift cards should be brought to every Child and Family Team Meeting and distributed to families who return the claim form. The returned claim form should be signed and dated. All completed claim forms must be filed by the Care Coordinator for monthly submission to EMSTAR Research. There must be a claim form signed for every gift card disbursed. Additionally, distributions of gift cards between the Evaluation Team and Wraparound Supervisors, and between WSs and their Care Coordinators must be recorded in hardcopy on the Gift Card Tracking Form and included in the monthly submission of claim forms to EMSTAR.
8. For the discharge administration of the YSS, the CC should remain with the family as the YSS is completed while giving the respondent privacy. Once completed, respondent should seal the YSS in the envelope and it should be placed in the mail by the CC. The CC will collect the claim form and provide the gift card during the same meeting. [A youth transitioning from CBAY to non-waiver Wraparound is not considered a discharge.]



Please answer the following questions to let us know how you are doing

24. How long did you receive services from this Center?

- a. Less than 1 month
- b. 1—2 months
- c. 3—5 months
- d. 6 months to 1 year
- e. More than 1 year

25. Are you still getting services from this Center? Yes No

26. Are you currently living with one or both parents? Yes No

27. Have you lived in any of the following places **in the last 6 months**? (CHECK ALL THAT APPLY)

- a. With one or both parents
- b. With another family member
- c. Foster home
- d. Therapeutic foster home
- e. Crisis shelter
- f. Homeless shelter
- g. Group home
- h. Residential treatment center
- i. Hospital
- j. Local jail or detention facility
- k. State correctional facility
- l. Runaway/homeless/on the streets
- m. Other (describe): _____

28. In the last year, did you see a medical doctor (nurse) for a health check up or because you were sick? (Check one)

Yes, in a clinic or office Yes, but only in a hospital emergency room No Do not remember

29. Are you on medication for emotional/behavioral problems? Yes No

29a. If yes, did the doctor or nurse tell you what side effects to watch for? Yes No

30. In the last month, did you get arrested by the police? Yes No

31. In the last month, did you go to court for something you did? Yes No

32. How often were you absent from school during the last month?

- 1 day or less
- 2 days
- 3 to 5 days
- 6 to 10 days
- More than 10 days
- Not applicable/ not in school
- Do not remember

Please answer the following questions to let us know a little about you.

Race: (Check two if needed)

American Indian/Alaskan Native White (Caucasian) Black (African American)
 Asian/Pacific Islander Other (describe): _____

Are either of your parents Spanish/Hispanic/Latino? Yes No

Gender: Male Female Transgender

Age: _____ **Today's Date:** _____

Do you have Medicaid insurance? Yes No Don't Know

Thank you for taking the time to answer these questions!



Youth Services Survey (YSS)

Youth Services Survey—Family (YSS-F)

Page Two

Example script to introduce YSS to families:

- *We are asking you to complete this form so that we can identify areas where our services are doing well and areas where our services could be improved.*
- *Completing the form should take 5-10 minutes.*
- *Your responses are anonymous. There is no identifying information on this form. We will not be able to link your responses back to you. Your responses will be grouped with responses from all other recipients of Wraparound services and reported as a whole.*
- *I, nor any of the staff that provide you services, will see this form. It will be mailed to EMSTAR Research, and company that is helping us with this study.*
- *Filling it out is voluntary. You can skip any item you are not comfortable answering.*
- *Your services will not be affected if you choose not to complete the survey.*
- *If you choose to complete the survey, we would like to thank you by giving you a \$5.00 Wal-Mart gift card. Once you complete the survey, bring the claim form on the last page of the survey to your next Child and Family Team Meeting to claim the gift card.*
- *Thank you!*

The WIN Georgia Evaluation Group

This listserv has been created in order to provide a public forum for those who are using these forms for service coordination or evaluation to learn from one another by posing and answering questions.

To join the group:

- Send an email to: WINGeorgiaEvaluation-subscribe@yahoogleroups.com
- You will receive an email from Yahoo to confirm your request to join. Select the link provided in the email.
- In the pop-up window that opens, select “JOIN.”
- You must have a Yahoo account to join. If you do not have one, create one (and remember your ID and password).
- Once this process is complete, you should automatically be taken to the WIN Georgia Evaluation homepage. If not, go to this address: <http://groups.yahoo.com/group/WINGeorgiaEvaluation>

To redirect your email to your LMCS address:

- Just above the title of the Group, you will see your Yahoo email address and a link that states: “Edit Membership.” Click that link.
- Click on the link that reads: “Add new email address.” This will take you to the *Manage your email addresses* page
- Follow the instructions to add a new email address.
- Return to the *Manage your email addresses* page and set your LMCS email address as primary.



Sample Script to Introduce the Longitudinal Child & Family Outcome Study

Overview of study:

- *EMSTAR Research is conducting a study of WIN Georgia. An interviewer from the study will be contacting you soon to explain more about it.*
- *The purpose of the study is to improve services that you get through WIN Georgia and to make it easier for children and families to receive the care they need.*
- *The study includes interviews with you, the caregiver, and your child who is in WIN Georgia if he or she is 11 years or older.*
- *Participation is:*
 - ◊ *Voluntary, meaning you don't have to participate*
 - ◊ *If you decide to participate, you can quit at any time*
 - ◊ *The services you receive will not be effected regardless of your decision to participate*
 - ◊ *The responses you give will be kept strictly confidential*
- *If you decide to participate, you and your child will be given a \$20 Wal-Mart gift card for each interview to thank you for your time.*

Wrapping up:

Remember that the information you give through the study will be very helpful to us. You are not making a decision now about whether or not to participate. You will be getting a call in the next week to tell you more about the study and you can decide if you want to participate then.

Other information (if family has questions):

- *Caregivers must give permission for their child to participate. Youth must also give their permission to participate.*
- *Interviews will take place in this first month and every 6 months for 2 years, so you will be interviewed a total of 5 times.*
- *Each caregiver interview should take between 1 ½ to 2 hours.*
- *Child interviews take about 1 hour.*



CME Forms & Function Instructional Guide

The Cheat Sheet

The Forms and Function Instructional Guide is designed to assist *Care Coordinators, Family Support Partners, Wrap-around Supervisors, and Directors* in properly completing and submitting all practice forms.

The Guide answers general questions about the function of a form and specifically how the form is completed and submitted. The latter is presented as CLARIFICATION POINTS.

For all clarification questions, please contact your CME Management.

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