What You Should Know About High Fidelity Wraparound / Intensive Customized Care Coordination (IC3)

Wraparound creates a team (with you as the leader) with the people that already know your family (and others we may choose together) to create ONE unified plan to reach your goals. We want to create a best fit plan that matches **your** hopes, dreams, strengths and needs that make your family special. We are invested in improving outcomes including keeping families together safely, shortening lengths of stays in out of home treatment, decreasing juvenile justice and child welfare involvement, increasing community engagement and improving school results.

We partner you with a Care Coordinator who will provide intensive in-home support, community linkages, safety and crisis planning, team building, and a customized plan of care. Additionally, you are partnered with a Certified Peer Specialist who serves as a parent peer support offering advocacy, education, skills building, and empowerment working towards a family vision for a healthy and successful life together. We focus on identifying and developing strengths of the youth, family, and supports to help your youth remain with you in your own community.

We will focus on:

- Planning for the safety of all family members
- The things that you all enjoy doing and the people you count on for hope and support
- Who and what has helped to pull you through difficult situations in the past
- Building on the amazing resources that you have to create new connections in your community

WRAPAROUND HAS TEN PRINCIPLES THAT WILL LEAD YOUR TEAM:

Family Voice and Choice ● Strength Based ● Culturally Competent
Team Based ● Collaborative ● Outcome Based ● Individualized
Community Based ● Natural Supports ● Unconditional Care

As System of Care Coordinators, we are available to provide further details, identify community resources, present information to providers, and offer support to families and teams.

South and Southwest Georgia

Hope Edwards 229.454.9014 hope.edwards@vphealth.org

East Georgia

Cassandra Hunter 470.462.8753 cassandra.hunter@vpheath.org

West Georgia

Channel Smith 229.376.6376 channel.smith2@vphealth.org

North, Metro and Central Georgia

Jennifer Wilds 770.856.8034 jennifer.wilds@vphealth.org

IC3 is a Medicaid billable service (including CMOs) and we will seek funding from DBHDD for families with no insurance and private insurances.

VIEW POINT Health
A Total Care Perspective

YOUTH WHO MAY BE APPROPRIATE…

Have a primary mental health diagnosis (may co-exist with substance related disorder and / or developmental disabilities)

Are at risk of out of home treatment due to potential hospitalization or involvement with DJJ or DFCS

Have experienced exposure to potentially traumatic or adverse childhood experiences

Have exhibited a serious risk of harm to themselves or others in the last six months

Have a history of attempted, but unsuccessful, follow through and past response to treatment has been minimal

Are interested in receiving intensive support at this time to maintain family and community integration

To access the View Point Health referral form, please go to our website or contact one of our System of Care Coordinators

https://www.myviewpointhealth.org/about/programs-a-to-z/referrals/

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CME Intensive Customized Care Coordination

Date of Referral: _____

Please email completed referral form and any supporting documentation to View Point Health Care Management Entity (CME) at familywrap@vphealth.org

Youth's Name: _____ DOB: _____ Age: ___ Gender: _____

Race: _____ Primary Language _____ Insurance Carrier: _____ Medicaid # (if applicable) _____

Parent/Guardian's Name: _____ Relationship to youth: _____ County: _____
Home/Placement Address: _____ City: _____ Zip:_____

Family Phone #: _____ Another # _____ Email Address: _____

Additional Contacts: Name: _____ Relationship: _____ Phone: _____ Email Address: _____

Referring Party Information ~ Name: _____ Email: _____ Phone: _____

☐ Parent/Guardian	☐ DBHDD Core Provider	☐ System of Care (LIPT/CHINS/CSEC)
☐ Inpatient Hospital	☐ Private Provider or Pediatrician	☐ School System
☐ Residential Facility (PRTF)	☐ Juvenile Court	☐ Crisis Stabilization Unit (CSU)
☐ DJJ In Community	☐ DFCS Family Preservation	☐ Family Support Organization
☐ DJJ Secure Facility	☐ DFCS Custody (GA Families 360)	☒ Other: **Channel Smith SOCC VPH**

DJJ Use Only: Juvenile ID _____ If DJJ Secure Facility, name of facility _____
DFCS/DJJ Use Only: Amerigroup Care Coordinator (Name & Contact Information) _____

Other Agencies Currently Involved:

☐ Enrolled in School (check if YES)	☐ DBHDD Core Provider	☐ Family Support Organization
☐ Inpatient Hospital	☐ Private Provider or Pediatrician	☐ Law Enforcement
☐ PRTF (Residential Facility)	☐ Juvenile Court	☐ Crisis Stabilization Unit
☐ Child Caring Inst. (Group Home)	☐ DFCS (non-custody only)	☐ Georgia Cares (CSEC)
☐ Dept. of Juvenile Justice	☐ DFCS Custody (GA Families 360)	☐ Other: _____

School Attending: _____ School Grade: _____ Special School Services: _____ ☐ IEP ☐ 504 Plan

Current Mental Health Diagnoses: _____ Other Diagnoses: _____
Current Medication(s): _____ Do you have a CANS you are able to share with us? ☐ Yes ☐ No

Please provide a brief youth and family history: _____
Describe challenges the youth is having: (i.e. at home, in school and in the community): _____

Presenting Problems: Please select all applicable emergent and crisis needs:
☐ Self-harm ☐ Suicidal thoughts ☐ Suicide attempt ☐ Threats of Violence ☐ Homicidal thoughts or behaviors
☐ Runaway ☐ Active Substance Use ☐ Imminent Risk of Out-of-Home Placement ☐ Other: _____

Child / Behavioral Needs: ☐ Psychosis ☐ Attention/Concentration ☐ Impulsivity ☐ Depression ☐ Anxiety
☐ Substance Abuse ☐ Attachment Difficulties ☐ Anger Control ☐ Other: _____

Past or current exposure to Potentially Traumatic / Adverse Childhood Experiences:
☐ Sexual Abuse ☐ Physical Abuse ☐ Emotional Abuse ☐ Neglect ☐ Witness to Family Violence ☐ Community Violence ☐ School Violence ☐ Disruptions in Caregiving/Attachment Losses ☐ Other: _____

Life Functioning Needs:
☐ Family ☐ Living Situation ☐ Social Functioning ☐ Legal ☐ Sleep ☐ Recreational ☐ School Behavior

Please select any of the following services the youth has received in the past 6 months:

☐ Inpatient Hospital # of Inpatient Admissions ___	☐ DJJ ☐ DFCS / CCI / CPA	☐ Youth Development Center ☐ Crisis Stabilization Unit
☐ Residential Treatment Facility # of PRTF Admissions ___	☐ Juvenile Court ☐ RYDC # of Stays ___	# of CSU Admissions ___ ☐ Other: _____

Has youth/family been presented at LIPT or CHINS? ☐ Yes ☐ No If yes, team recommendation: _____
Has the family been informed about services provided by View Point Health and provided consent for the referral? ☐ Yes ☐ No

Please return completed form and any supporting documentation to familywrap@vphealth.org
We will review your referral and contact you within three business days to discuss. We look forward to working with you!