

YOUTH WHO MAY BE APPROPRIATE...

Have a primary mental health diagnosis (may coexist 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.myviewpointhe alth.org/about/programs-ato-z/referrals/



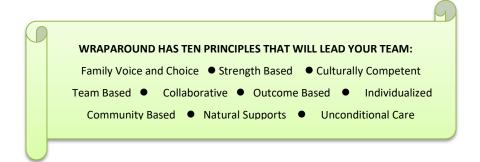
What You Should Know About High Fidelity Wraparound / Intensive Customized Care Coordination (IC3)

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



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 <u>hope.edwards@vphealth.org</u>

East Georgia

Cassandra Hunter 470.462.8753 cassandra.hunter@vpheath.org

West Georgia

Channel Smith 229.376.6376 <u>channel.smith2@vphealth.org</u>

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.



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 Langu	guage Insurance Carrier:		Medicaid # (if applicable)			
Parent/Guardian's Name: Home/Placement Address:			County: Zip:			
Family Phone #:	Another#	Email Address	s:			
Additional Contacts: Name:	Relationship:	Phone:	_ Email Ad	dress:		
Referring Party Information ~ Name	·	Email:		Phone:		
☐ Parent/Guardian ☐ Inpatient Hospital ☐ Residential Facility (PRTF) ☐ DJJ In Community ☐ DJJ Secure Facility	☐ DBHDD Core Provide ☐ Private Provider or F ☐ Juvenile Court ☐ DFCS Family Preserv ☐ DFCS Custody (GA Fa	Pediatrician ation	School Sy Crisis Sta Family Su	f Care (LIPT/CHINS/ stem bilization Unit (CSU) upport Organization nannel Smith SOC)	
DJJ Use Only: Juvenile ID DFCS/DJJ Use Only: Amerigroup Ca	•		ion)			
Other Agencies Currently Involved:						
□ Enrolled in School (check if YES) □ DBHDD Core Provider □ Inpatient Hospital □ Private Provider or Pediatricia □ PRTF (Residential Facility) □ Juvenile Court □ Child Caring Inst. (Group Home) □ DFCS (non-custody only) □ Dept. of Juvenile Justice □ DFCS Custody (GA Families 360)		or Pediatrician dy only)	Law Enfo	bilization Unit Cares (CSEC)		
School Attending: Scho	ol Grade: Speci	al School Service	es:	☐ IEP ☐ 504 I	Plan	
Current Mental Health Diagnoses: Current Medication(s): Please provide a brief youth and fan	[Other Diagnoses Do you have a CA		le to share with us?	Yes No	
Describe challenges the youth is have		ol and in the co	mmunity):			
Presenting Problems: Please select a Self-harm Suicidal thoughts Runaway Active Substance Child / Behavioral Needs: Psyc	Suicide attempt 13 Use 13 Imminent Risk of	Threats of Violen FOut-of-Home P	Placement []	Other:		ety
Substance Abuse Attachme		Control 0			_	
Past or current exposure to Potentia Sexual Abuse Physical Abus Violence School Violence	- <u>-</u>	☐ Neglect	Witness to F	amily Violence er:	Community	
Life Functioning Needs: Family Living Situation	Social Functioning	Legal 🗌 Sleep	Recreation	onal School B	ehavior	
Please select any of the following se	rvices the youth has recei	ved in the past	6 months:			
Inpatient Hospital # of Inpatient Admissions Residential Treatment Facility # of PRTF Admissions	DJJ DFCS / CCI / CPA Juvenile Court RYDC # of Stays		Youth De	velopment Center pilization Unit Admissions		
Has youth/family been presented at Has the family been informed about					I? □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!