

Attached find an application for Children's Mental Health Wraparound (Wraparound). Here are some things to know to expedite processing of your application:

Eligibility Criteria for Wraparound Services:

Children and youths aged 0-21 who meet the following criteria:

1. Have mental health or co-occurring diagnoses that substantially interfere with or limit their functioning in family, school, or community activities;
2. Are at risk of placement, or are currently placed in a psychiatric treatment facility or acute care psychiatric hospital, and cannot return home without extra support, linkage, and services provided by Wraparound; and
3. Are emancipated or in the legal custody of their parent or caregiver.

Completion of Application:

1. Application should be filled out with as much information as possible and they must include the signed consent and release sheet on page 2. If the application isn't filled out or the consent and release sheet is not completed, the application will be considered incomplete and will be returned to you for completion.
2. Contact information should be up to date and accurate including contact phone numbers and emails.
3. Applications should be legible.

Definition of Terms Used:

1. **Parent:** an individual defined as parent by law or on the basis of a biological relationship, marriage to a person with a biological relationship, legal adoption or other recognized grounds
2. **Legal or minor guardianship:** the permanent relationship between a child and a caretaker, established by the order of a court having jurisdiction over the child or juvenile.

Children's Mental Health Wraparound Referral Form

It is ideal for a parent/ legal guardian or child to call, but if you have spoken at length with the parent/legal guardian or child, who approves of being referred, please complete this form and send it to DHHRBBHWraparoundReferrals@wv.gov at the WV Bureau for Behavioral Health

Referral Source:	
Date of Referral:	
Name of Referral Source:	
Relationship to Child/Youth	
Phone Number:	

Family Information:			
Name of parent(s):		Contact/Phone:	
Relationship to Child/Youth?			
Address:		County of Residence:	
Does this parent have legal guardianship of the child?		If not, in who has legal guardianship of the child?	
Does the family have an active BCF case (i.e., Child Protective Services, Youth Services, or Adult Services) If yes, list type of case and what county?		Does the family have a safety plan in place?	
Does the family have active court case? (If so, please give case type e.g., child abuse/neglect, juvenile, family court, criminal)		County of Case and Judge:	

Please have parent/ legal guardian (or adult youth) sign the consent to contact on the subsequent page, so that that we may contact him/her with further questions or to update on the status of the referral.

Child Information:			
Child Name:		Date of Birth:	
Age:		Gender:	
Mental Health Diagnosis:			
Intellectual/Developmental Disability (IDD):			
If IDD What is the child's waiver status (i/e., not eligible, has not applied, on waiting list, currently has waiver)?			

Where is the child having problems (i.e., in home, school, community)	
Services the Child currently receives/accesses:	

Name of School:			
Current Grade Level:			
Is there a current IEP?		What is the IEP for?	
Is the child currently expelled from school?		If yes, when was this effective?	

Presenting Problem(s):

Placement Risk/History:	
Is the child at risk of out-of-home placement?	
Is the child currently in acute care, psychiatric residential (PRFT), or another type of placement? (Please give facility and length of stay)	
Placement History (please give places and dates, if available):	

Please share anything else that may be helpful for this referral:

Send this completed referral to DHHRBBHWraparoundReferrals@wv.gov Questions: Call (304) 356-4811 M-F 8:00 a.m. – 4:00 p.m. Fax Number: (304) 558-1008 ATT: Vicky Hatfield.

Authorization for Follow-Up on Referral to WV Children's Mental Health Wraparound

I, _____, am interested in participating in the Children's Mental Health Wraparound Process. I approve of _____ sending a referral on my behalf, or on my child's behalf to the WV Bureau for Behavioral Health (BBH).

_____(initial) I authorize the Bureau for Behavioral Health and their grantees to contact me with questions about my eligibility and to update me on the status of my request for Wraparound. The best way to contact me is; _____.

_____(initial) If I am approved for Wraparound, the Bureau for Behavioral Health and their grantees may send my referral to a local behavioral health agency to begin the Wraparound process with me and my family. This referral will contain sensitive information about my or my child's behavioral health and out-of-home placement history.

_____(initial) I understand that Wraparound is a voluntary process that I may terminate at any time.

Effective Period

This authorization is in effect from _____, 20____, to _____, 20_____.

_____(initial) I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained. Please send revocation to Cassandra Toliver 350 Capitol Street, Room 350, Charleston, WV 25301 or you may email your revocation to DHHRBBHWraparoundReferrals@wv.gov.

Name of Child: _____

Name of Legal Guardian: _____

Signature of Legal Guardian: _____

Signature of Young Adult: _____

Date: _____