WRAPAROUND MILWAUKEE Policy & Procedure	Date Issued: 9/1/98	Reviewed: 10/19/11 By: MJM/DT Last Revision: 11/17/11	Section: ADMINISTRATION	Policy No: 004	Pages: 1 of 3 (8 Attachments)
☒ Wraparound ☐ Wraparound-REACH ☐ FISS ☐ Project O-Yeah	Effective Date: 1/1/12	Subject: **OUT-OF-HOME CARE REFERRALS AND AUTHORIZATIONS**			

I. POLICY

It is the policy of Wraparound Milwaukee to preauthorize all new placements in Residential Care Centers for Children & Youth (RCCCY's), Group Homes, Foster Care and Supported Independent Living (all phases), as well as review requests for placement extensions to ensure adherence to providing quality care to youth in the safest, least restrictive setting. The purpose of the Out-of-Home Care Authorization Process is to document expected placement outcomes and to ensure quality collaboration between families, community agencies and out-of-home care facilities.

II. PROCEDURE

A. Placements Initiated by Child & Family Team.

1. If a youth's needs rise to the level of a possible Out-of-Home placement, as identified by a member of the Child & Family Team, a Child & Family Team meeting must occur. The Child & Family Team must once again review all Strengths, Needs, Strategies and Resource options to determine the appropriate action to be taken by the Team members. Options of alternate resources, supports and/or consultations must be considered. If all possible resources have been exhausted, and out-of-home placement is going to be requested, the Care Coordinator must update the youth's Plan of Care (POC) to reflect this.
2. The POC must be approved by the Supervisor/Lead, as usual.
3. The Care Coordinator submits the POC SIGNATURE SHEET (*see Attachment 1)* for final POC approval from Wraparound Milwaukee, checking the "Submit for Prior Auth Review" box and the requested level of care. This will cue Wraparound staff that the POC contains a request for out-of-home care, and the POC and a Cover Sheet will be forwarded to the appropriate Wraparound Manager for review.
4. The Wraparound Manager will review the form for authorization. More information or documentation may be requested prior to authorization being considered.
5. **A decision to approve or deny the request will be made within four (4) days of receipt of a COMPLETE request.** Care Coordinators will be notified as to whether or not the request has been approved via a login message in Synthesis.
6. **If Approved,** the Care Coordinator must have an AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION form (*see Attachment 2)* completed and signed by the youth and guardian for all group home and residential placements. If the Team is seeking foster care, the Care Coordinator must have an AUTHORIZATION TO RELEASE HEALTH INFORMATION FOR FOSTER CARE *(see Attachment 3)* completed and signed by the youth and guardian. The Care Coordinator and Team must complete the OUT-OF-HOME REFERRAL FORM *(under the Forms Tab in Synthesis – see Attachment 4),* the WHAT YOU SHOULD KNOW ABOUT ME FORM *(see Attachment 5),* letters of introduction or support from Team members, the Plan of Care and the most recent Psychological Evaluation. Referral packets for residential and group home care can be distributed directly to those agencies identified on the Release/Exchange of Information form. Foster Care referral packets should be submitted to the Wraparound Milwaukee Program Coordinator. The Care Coordinator also needs to complete a CANS (*Child and Adolescent Needs and Strengths assessment – see Attachment 6)* with the Team and enter it into Synthesis if foster care is being considered. The Care Coordinator should arrange for and facilitate tours or home visits of facilities or potential homes with youth and families.

Note: ALL YOUTH PLACED IN RESIDENTIAL, GROUP HOME, FOSTER CARE OR SUPPORTED INDEPENDENT LIVING MUST HAVE OUT-OF-HOME CARE PRIOR AUTHORIZATION UPON ADMISSION. *For the first out-of-home authorization, Care Coordinators should print off a copy of the approved Authorization form from Synthesis and give to the placement provider to conform authorization for placement/payment.*

7. **If Denied,** alternative recommendations will be provided to the Care Coordinator to consider with the Child & Family Team. If the Child & Family Team disagrees, the Care Coordinator may appeal the decision by contacting the Deputy Director of Wraparound Milwaukee at (414) 257-7521.

B. Court-Ordered On or During Enrollment.

1. If a youth is court-ordered into an Out-of-Home placement upon enrollment, the Care Coordinator will be notified of this on enrollment and a copy of an initial 30-day authorization will be included in the enrollment packet. If the Court or Wraparound Milwaukee assessment team has not already determined the home or facility, the Care Coordinator should determine which homes or facilities have openings appropriate to the youth's needs and arrange for tours or visits in a timely manner.
2. If a youth is unexpectedly, and/or against the team's recommendations, ordered into an Out-of-Home placement during enrollment, the Care Coordinator must then submit the Docket Sheet to their Liaison as soon as possible, highlighting the area that indicates the youth has been ordered into an out-of-home placement. The Care Coordinator must then follow the referral steps listed under section A.6. as indicated. There will be an administrative authorization approval entered that will be valid for the first 30 days of placement. This authorization will appear on the youth's prior authorization screen in Synthesis and will contain a short statement from authorizing staff outlining the expectations for the Care Coordinator and the facility/home for the first authorization period.
3. **Within the first 21 days of placement,** the Care Coordinator will then coordinate a Plan of Care meeting to determine the needs for treatment upon locating an appropriate placement facility and/or upon placement in the facility. **The POC must be submitted within 30 days of enrollment and/or within 30 days of the court-ordered placement.**

C. Other Special Circumstances.

1. If the placement is done on an emergency basis – an Initial Prior Authorization request MAY BE SUBMITTED, which does not include out-of-home care as part of the strategies in the current POC.
2. At a minimum, a Team meeting should be called immediately to discuss how the out-of-home placement will be integrated into the Plan.
3. This Team meeting must be documented in Synthesis, and will print as part of the Prior Authorization Cover Sheet that is printed by Wraparound.
4. The most current POC – in conjunction with the data on the Cover Sheet, which includes the Team meeting note – will be reviewed instead. (Care Coordinators may want to put a notation on the POC Signature Sheet to indicate that a team meeting only was held to ensure that the authorization is not rejected.)
5. The remainder of the authorization process will continue as listed above.
6. The initial authorization period will generally be for no more than **14** days, during which time it is expected that a Plan of Care meeting will occur, and the Care Coordinator will submit a re-authorization request.

D. Renewals.

1. If placement is expected to continue beyond the expiration date of the current Authorization, a new POC must be submitted **14 days prior to the expiration date of the current Authorization**. Agency clerical staff shall be assigned to run the "Out-of-Home Prior Authorization Expiration Dates" report in Synthesis on or around the 10th day of each month, and notify Care Coordinators of

expiring authorizations. Supervisors should monitor that the Re-Authorization requests are completed and submitted no later than the 15th day of each month.

2. The Care Coordinator must facilitate a Plan of Care meeting at least twenty (20) working days prior to the Authorization expiration date to review the progress to date achieved through interventions by the placement Provider, as well as what supports and resources the Child & Family Team has utilized during the youth's placement. The Child & Family Team should determine what has been successful and helpful and support those resources. After this review by the Child & Family Team, the Plan of Care must be revised to meet the youth's and family's continuing needs, as well as clearly stating the transition plan and timelines for transition.
3. The POC should be submitted as noted above.
4. In addition to all paperwork required under Section A, a Progress Report is required from the placement facility. The OUT-OF-HOME CARE PROGRESS REPORT (*see Attachment 7*) must be completed by the treatment Provider and submitted via Synthesis. For youth in RCCCY's, who are adjudicated as a Juvenile Sex Offender or receiving specialized treatment due to a history of sexual behavior problems (non-adjudicated), the OUT-OF-HOME CARE PROGRESS REPORT AND the JSO TREATMENT PROGRESS REPORT (*see Attachment 8)* must be completed by the treatment Provider and submitted via Synthesis. The Care Coordinator should remind the facility-based therapist of this need as a regular part of the ongoing and frequent Child & Family Team meetings. A copy of this report must be shared with all Team members.

Reviewed & Approved By: Bruce Kamradt

Bruce Kamradt, Director

WRAPAROUND MILWAUKEE
Out-of-Home Care Policy
Attachment 1

SUBMIT FOR PRIOR AUTH REVIEW? _____ Yes _____ No
If yes, ____ Initial _____ Re-Authorization
If yes, _____ Day Treatment _____ RCCCY ____Foster Care
_____ Group Home _____ Independent Living

WRAPAROUND MILWAUKEE

POC/Child and Family Team Meeting Signature` Sheet

POC Date: _____

Youth Name: _____ Date of Birth: _____

Care Coordinator Name/Agency Name:_____

REQUIRED TEAM MEMBER SIGNATURES

			In Attendance?
Youth	Phone	E-mail address	☐ Yes ☐ No
Parent/Legal Guardian	Phone	E-mail address	☐ Yes ☐ No
Parent/Legal Guardian	Phone	E-mail address	☐ Yes ☐ No
Care Coordinator	Phone	E-mail address	☐ Yes ☐ No
Care Coord. Supervisor	Phone	E-mail address	☐ Yes ☐ No

✓Client Rights Reminder

Enrollee/parent/ legal guardian:

By signing this form you do not give up your right to grieve or appeal what is written in this Plan or the services you are receiving.

Consulting Psychologist	Date	Phone	E-mail address	Yes ☐ No ☐
Consulting Psychiatrist	Date	Phone	E-mail address	Yes ☐ No ☐

SIGNATURES OF ADDITIONAL TEAM MEMBERS

Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address

POC Date: _____

Youth Name: _____ **Date of Birth:** _____

Care Coordinator Name/Agency Name:_____

SIGNATURES OF ADDITIONAL TEAM MEMBERS

Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address
Team Member	Relationship To Youth	Phone	E-mail address

WRAPAROUND MILWAUKEE / REACH
AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

PURPOSE OF INFORMATION RELEASE/EXCHANGE:

Release / exchange of mental health (Enrollment notification and information, Plan of Care – including diagnosis/prognosis, and Progress Reports) AODA (Alcohol and Other Drug Addiction), physical health, school progress information and *Other documents that will be used to plan and provide for the care, treatment and services for:

_____ _____

(Youth's Name) **(Date of Birth)**

I authorize Wraparound Milwaukee, its contracted Care Coordination Agencies, and the Mobile Urgent Treatment Team to release and exchange information with staff at the agencies identified below. Information may be shared verbally or in writing.

AGENCY NAME / INDIVIDUAL NAME

1. **Agency/Individual** (please print): _____

   Address (please print): _____

   ***Identify Other Document/s:** _____

2. **Agency/Individual** (please print): _____

   Address (please print): _____

   ***Identify Other Document/s:** _____

3. **Agency/Individual** (please print): _____

   Address (please print): _____

   ***Identify Other Document/s:** _____

4. **Agency/Individual** (please print): _____

   Address (please print): _____

   ***Identify Other Document/s:** _____

EXPIRATION OF AUTHORIZATION / WITHDRAWAL OF AUTHORIZATION

If not specified below, I understand that this Authorization to Release/Exchange Information EXPIRES 12 MONTHS from the date it is signed. I understand that I may cancel this authorization at any time (see back of sheet for instructions). This cancellation does not include any information that has been shared between the time I gave my consent to share information and the time that the consent was canceled.

This authorization expires on the _____ day of _____, 20_____.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

_____ _____

Parent or Legal Guardian Signature **Date**

_____ _____

Youth Signature (*age 14 and older should sign)* **Date**

_____ _____

Witness Signature **Date**

PARTICIPANT RIGHTS RELATED TO AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization - I understand that if I sign this authorization, I will be provided with a copy of this authorization.

Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that Wraparound Milwaukee may not condition treatment, payment, or enrollment on my decision to sign this authorization.

Failure to Sign - I understand that failure to sign this authorization may severely limit the treatment / service options available for my child or family. If my child is enrolled in Wraparound Milwaukee as part of a court order, I understand that failure to sign this form may result in a request to the courts to modify the court order that allows for enrollment in the Wraparound Milwaukee program.

Right to Withdraw This Authorization - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Pamela Erdman, Wraparound Milwaukee Quality Assurance. (The statement must be dated and signed). I am aware that my withdrawal will not be effective until received by Wraparound Milwaukee and will not be effective regarding the uses and/or disclosures of my health information that Wraparound Milwaukee has made prior to receipt of my withdrawal statement

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be released/exchanged by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Pamela Erdman in the Wraparound Milwaukee Quality Assurance Department.

HIV Test Results - I understand my child's HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

Submit your written requests for withdrawal to:

Ms. Pamela Erdman, Wraparound Milwaukee Quality Assurance Director
Wraparound Milwaukee Administrative Offices
9201 Watertown Plank Road
Milwaukee, WI 53226 Phone: (414) 257-7608

WRAPAROUND MILWAUKEE

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FOR FOSTER CARE

PURPOSE OF DISCLOSURE:
Release of Mental Health, AODA (Alcohol and Other Drug Addiction) and physical health information that will be used to plan and provide for the care, treatment and services for:

_____ _____
(Youth's Name) (Date of Birth)

I authorize Wraparound Milwaukee, its contracted Care Coordination Agencies, and/or the Mobile Urgent Treatment Team to release/exchange health related information including diagnosis, prognosis, treatment and planning related to the above named youth's enrollment in Wraparound Milwaukee to the appropriate staff at the following agency/s:

AGENCY NAME / INDIVIDUAL NAME	SHARED DOCUMENTS/INFORMATION (Check those that apply.)			
	Demographic Information Only	Plan of Care	Referral for Services	Other * (Specify Below)
☐ **ANU Family Services**	☐	☐	☐	☐
☐ **Benevolence First, Inc.**	☐	☐	☐	☐
☐ **Brighter Destinies**	☐	☐	☐	☐
☐ **Children's Service Society of Wisconsin**	☐	☐	☐	☐
☐ **Community Care Resources, Inc.**	☐	☐	☐	☐
☐ **Family Works Programs, Inc.**	☐	☐	☐	☐
☐ **FreshStart Counseling Center**	☐	☐	☐	☐
☐ **Harmony Social Services CPA, Inc.**	☐	☐	☐	☐
☐ **LaCausa, Inc.**	☐	☐	☐	☐
☐ **My Home, Your Home**	☐	☐	☐	☐
☐ **New Horizons**	☐	☐	☐	☐
☐ **St. Aemilian - Lakeside**	☐	☐	☐	☐
☐ **St. Charles Youth & Family Services, Inc.**	☐	☐	☐	☐
☐ **Thrive Treatment Foster Care, LLC**	☐	☐	☐	☐
☐ **BMCW Block_____**	☐	☐	☐	☐

EXPIRATION OF AUTHORIZATION / WITHDRAWAL OF AUTHORIZATION
If not specified below, I understand that **this Authorization for Release of Information EXPIRES 12 MONTHS from the date it was signed**. I understand **that I may cancel this authorization at any time** (see back of sheet for instructions). This does not include any information that has been shared between the time I gave my consent to share information and the time that the consent was canceled**.**

This authorization expires on the _____ day of _____, 20_____.

REDISCLOSURE NOTICE: I understand that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

Parent or Guardian Signature_____ **Date**_____

Youth Signature_____ **Date**_____

Witness Signature_____ **Date**_____

CLIENT RIGHTS RELATED TO AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:

Right to Receive Copy of This Authorization - I understand that if I sign this authorization, I will be provided with a copy of this authorization.

Right to Refuse to Sign This Authorization - I understand that I am under no obligation to sign this form and that Wraparound Milwaukee may not condition treatment, payment, or enrollment on my decision to sign this authorization.

Failure to Sign - I understand that failure to sign this authorization may severely limit the treatment / service options available for my child or family.

Right to Withdraw This Authorization - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Pamela Erdman, Wraparound Milwaukee Quality Assurance Department. (The statement must be dated and signed). I am aware that my withdrawal will not be effective until received by Wraparound Milwaukee and will not be effective regarding the uses and/or disclosures of my health information that Wraparound Milwaukee has made prior to receipt of my withdrawal statement

Right to Inspect or Copy the Health Information to Be Used or Disclosed - I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Pamela Erdman in the Wraparound Milwaukee Quality Assurance Department**.**

HIV Test Results - I understand my child's HIV test results may be released without authorization to persons/organizations that have access under State law and a list of those persons/organizations is available upon request.

Submit your written requests for withdrawal to:

Ms. Pamela Erdman, Wraparound Milwaukee Quality Assurance Director
Wraparound Milwaukee Administrative Offices
9201 Watertown Plank Road
Milwaukee, WI 53226 Phone: (414) 257-7608

Wraparound Milwaukee

Out of Home Referral Form

Name: **Sample1, Client**
DOB: 1/1/90 **Referral Date:** **10/18/11**
Gender: Male Ethnicity:

Referral Submitted by:

Placement: History Since Enrollment

Date	*Type*	*Location*

Contact Information
Youth Client Sample1

Child and Family Team Members

Name	*Relationship*	*Type of Support*
Mary Sample	Relative in the home	*Neutral*
Sue smith	Friend	*Informal/Natural*

School Information

School	*Grade*	*Phone*	*ContactPerson*	*IEPDo*	*IEPDate*	*Spec Ed Types*

Legal Information

Order Type(s)	*Court Number*	*Exp Date*

Arrested Offenses

OffenseDate	*Offense*

Diagnoses:

Axis	*Description*
I	Attention Disorder

Diagnosed By:
Diagnosis Date:

Axis	*Description*
III	
IV	
V	

Current Medications

Type	*Used For*	*Dosage/Frequency*	*Prescribed By*	*Phone*
No Medication Information Exists				

Medical Information

CANS Information

Date	*Status*	*# Points*	*Supp.Rate*
2/1/11	Inc		
2/25/11	Inc		

Name(s) of Agencies Being Referred to

x

Service Requested

residential / foster care / group home / independent living

y

Strengths / Interests of the Child

please share some of what this child enjoys and does well

z

Strengths / Talents of the Team

please describe the resources of the child and family team and natural / community resources

a

Statement of Need / Expected Outcome from Placement

b

Community / Safety Concerns

c

Target Date for Placement

d

Anticipated Length of Placement

e

Special Staffing Pattern Required? If YES, explain

Will the youth require a special staffing pattern while in residence? If so - specify what those requirements are

f

GROUP HOME ONLY: Is a roommate OK?

No

GROUP HOME ONLY: Are there any peer age issues? If YES, explain.

I.e., younger, older or same-age peers required?

g

Primary Referral Issue

i.e., AODA, sex offense

h

Family History

Coping strategies and resources which have been helpful. Include relevant AODA, mental illness, domestic violence, treatment history of par

i

Current Family Involvement

Describe current contact, include family therapy and visitation between child and parents, siblings, relatives. Includes names, ages and addr

j

Cultural / Spiritual Considerations

Describe any child or family religious and/or cultural preferences

k

Abuse / Neglect History

Describe and date any alleged or substantiated incidents of physical, sexual or emotional abuse or neglect

l

Behavioral Functioning

Describe any special behavioral challenges faced by this child and his/her caretakers and the strategies which have proven most helpful in m

m

Cogitive / Emotional / Functioning

Describe any special intellectual and/or emotional challenges faced by this child and the strategies that have proven most helpful in meeting

n

Academic Functioning
List academic strengths, needs and the strategies that have proven most helpful in meething those needs
o

If a school change will be necessary as part of placement, what transition planning will be necessary to facilitate a smooth move?
p

Child's height and weight
q

Date of last physical
r

Is the physical attached?
No

Test Results
List any pertinent test results from the physical examination.
s

Physical Limitations
If there are none, list 'none.'
t

Visitation - CONTACT ALLOWED
Include name, phone number and relationship for each individual. Also indicate if supervised, unsupervised or phone-only contact is allowec
u

Visitation - NO CONTACT ALLOWED
Include name, phone number and relationship for each individual for whom NO contact is allowed. Include any other relevant information a
v

Critical Transition Information
What might contribute to a smooth transition from the current placement to the proposed placement?
w

What factors or interventions might prove most helpful and should be prioritized to increase the likelihood of a successful experience for this child and family.
x

How we will know if we have succeeded with this child and family?
y

Foster Care Match Factors

Foster Care Match Factors
Complete fields below for all foster care referrals
z

Within Milwaukee County?	No
Outside Milwaukee County?	No
2-Parent Household?	No
Single-Parent, Female?	No

Single-Parent, Male?	No
Same Gender Partner Households?	No
Roommate?	No
Racial Preference?	No
If YES, specify racial preference	sa
Younger Children in the Home?	No
Older Children in the Home?	No
No Children in the Home?	No
Are Pets OK?	No
Other Notes	bb

WHAT YOU SHOULD KNOW ABOUT ME!!!

Who Am I?

Name: _____

Age_____ **Hometown(where I grew up)**_____

This is what I want others to know about my family.

_____

_____

_____

_____

This is what I want other people to know about my education.

_____

_____

_____

_____

3 things that interest me.

1. _____
2. _____
3. _____

These are my STRONG points.

_____

_____

_____

These are things I want or need to work on.

_____

_____

_____

What are things that make me happy?

_____

_____

_____

What are things that make me upset?

These are things that help me calm down when I am upset

What type of music do I enjoy?

What are my favorite foods?

What are my hobbies? (what do I do for fun)

The people who are supports for me now are.....

The people I look up to most are.....

Looking at my Future.....

What do I need for a positive future?

_____

_____

_____

_____

The type of community that would be best for me is.....

_____

_____

_____

The type of place I want to live next is...

_____

_____

_____

3 goals for my future are...

1. _____
2. _____
3. _____

The type(s) of job(s) I'm interested in would be....

_____

_____

_____

The type of education I want for my future is.....

_____

_____

_____

Looking at my concerns.....

My biggest mistakes have been.....

How I feel about my mistakes.....

Something I want someone to forgive me for is....

My biggest concerns or questions are....

When someone works with me its helpful if ....

When someone works with me it is <u>not</u> helpful when....

Sometimes people misjudge me and what I want people to know about me is...

Showing my talents.....

I am talented.... My talents are.....

_____

_____

_____

USE THE SPACE BELOW TO CREATE SOMETHING THAT TELLS ABOUT YOU (POEM, PICTURE, SONG, STORY, ETC....)

CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS) — WISCONSIN COMPREHENSIVE

Please √ appropriate use: ☐ Initial ☐ Reassessment ☐ Transition/Discharge

Date: M M D D Y Y

Child/Youth's Name _____ DOB m m d d y y _____ Gender M F _____ Race/Ethnicity _____

Current Living Situation: _____

Assessor (Print Name): _____ Signature _____

Identified Permanent Resource Name: _____ Relation: _____

Current Caregiver Name: _____ Relation: _____

TRAUMA (*Characteristics of the trauma experience*)

	0	1	2	3
Sexual Abuse*	○	○	○	○
Physical Abuse	○	○	○	○
Neglect	○	○	○	○
Emotional Abuse	○	○	○	○
Medical Trauma	○	○	○	○
Natural Disaster	○	○	○	○
Witness to Family Violence	○	○	○	○
Witness to Community Violence	○	○	○	○
Witness/Victim - Criminal Acts	○	○	○	○
Other:				
If Sexual Abuse >0, complete the following:				
Emotional closeness to perpetrator	○	○	○	○
Frequency	○	○	○	○
Duration	○	○	○	○
Force	○	○	○	○
Reaction to Disclosure	○	○	○	○
Adjustment	**0**	**1**	**2**	**3**
Adjustment to Trauma	○	○	○	○
Traumatic Grief/Separation	○	○	○	○
Intrusions	○	○	○	○
Attachment	○	○	○	○
Dissociation	○	○	○	○

LIFE DOMAIN FUNCTIONING

0 = no evidence of problems 1 = history, mild
2 = moderate 3 = severe

	0	1	2	3
Family-nuclear	○	○	○	○
Family-extended	○	○	○	○
Living Situation	○	○	○	○
Social Functioning-Peer	○	○	○	○
Social Functioning-Adult	○	○	○	○
Developmental[1]	○	○	○	○
Legal[2]	○	○	○	○
Eating Disturbance	○	○	○	○
Sleeping	○	○	○	○
Medical[3]	○	○	○	○
Physical	○	○	○	○
Dental	○	○	○	○
Sexual Development	○	○	○	○
Daily Functioning	○	○	○	○
Life Skills	○	○	○	○

SCHOOL

0 = no evidence 1 = minimal needs
2 = moderate needs 3 = severe needs

	0	1	2	3
Attendance	○	○	○	○
Behavior	○	○	○	○
Achievement	○	○	○	○
Relation with Teachers	○	○	○	○

CHILD/YOUTH STRENGTHS

0 = centerpiece 1 = useful
2 = identified 3 = not yet identified

	0	1	2	3
Family-nuclear	○	○	○	○
Family-extended	○	○	○	○
Positive Peer Relations	○	○	○	○
Optimism	○	○	○	○
Decision-making	○	○	○	○
Well-being	○	○	○	○
Educational	○	○	○	○
Recreation	○	○	○	○
Vocational	○	○	○	○
Talents / Interests	○	○	○	○
Spiritual / Religious	○	○	○	○
Community Life	○	○	○	○
Relationship Permanence	○	○	○	○
Youth Involvement	○	○	○	○
Natural Supports	○	○	○	○
Resiliency	○	○	○	○
Resourcefulness	○	○	○	○

CHILD/YOUTH & FAMILY ACCULTURATION

0 = no evidence 1 = minimal needs
2 = moderate needs 3 = severe needs

	0	1	2	3
Language	○	○	○	○
Identity	○	○	○	○
Ritual	○	○	○	○
Cultural Stress	○	○	○	○
Knowledge congruence	○	○	○	○
Helpseeking congruence	○	○	○	○
Expression of distress	○	○	○	○

CHILD/YOUTH BEHAVIORAL / EMOTIONAL NEEDS

0 = no evidence
1 = history or sub-threshold, watch/prevent
2 = causing problems, consistent with diagnosable disorder
3 = causing severe/dangerous problems

	0	1	2	3
Psychosis	○	○	○	○
Impulse / Hyper	○	○	○	○
Depression	○	○	○	○
Anxiety	○	○	○	○
Oppositional	○	○	○	○
Conduct	○	○	○	○
Anger Control	○	○	○	○
Substance Use	○	○	○	○
Somatization	○	○	○	○
Behavioral Regression	○	○	○	○
Affect Dysregulation	○	○	○	○

CHILD/YOUTH RISK BEHAVIORS

0 = no evidence 1 = history, watch/prevent
2 = recent, act 3 = acute, act immediately

	0	1	2	3
Suicide Risk	○	○	○	○
Self Injurious Behavior	○	○	○	○
Other Self Harm	○	○	○	○
Exploited	○	○	○	○
Danger to Others	○	○	○	○
Sexual Aggression	○	○	○	○
Delinquent Behavior	○	○	○	○
Runaway[4]	○	○	○	○
Intentional Misbehavior	○	○	○	○
Fire setting	○	○	○	○
Bullying	○	○	○	○

IDENTIFIED PERMANENT RESOURCE STRENGTHS & NEEDS

○ Not applicable – no caregiver identified

0 = no evidence 1 = minimal needs
2 = moderate needs 3 = severe needs

	0	1	2	3
Supervision	○	○	○	○
Involvement with care	○	○	○	○
Knowledge	○	○	○	○
Organization	○	○	○	○
Problem Solving	○	○	○	○
Social Resources	○	○	○	○
Residential Stability	○	○	○	○
Physical Health	○	○	○	○
Mental Health	○	○	○	○
Substance Abuse	○	○	○	○
Developmental	○	○	○	○
Self Care	○	○	○	○
Access to Child Care	○	○	○	○
Family Stress	○	○	○	○
Empathy with child	○	○	○	○
Acculturation	○	○	○	○
Employment	○	○	○	○
Education	○	○	○	○
Financial Resources	○	○	○	○
Community Connect	○	○	○	○
Legal	○	○	○	○
Transportation	○	○	○	○
Safety	○	○	○	○

CURRENT CAREGIVER

	0	1	2	3
Supervision	○	○	○	○
Problem Solving	○	○	○	○
Involvement with care	○	○	○	○
Knowledge	○	○	○	○
Empathy with child	○	○	○	○
Organization	○	○	○	○
Social Resources	○	○	○	○
Physical Health	○	○	○	○
Mental Health	○	○	○	○
Substance Use	○	○	○	○
Developmental	○	○	○	○
Family Stress	○	○	○	○
Cultural Congruence	○	○	○	○

MODULES

1-DEVELOPMENTAL NEEDS (DD)

	0	1	2	3
Cognitive	○	○	○	○
Autism Spectrum	○	○	○	○
Communication	○	○	○	○
Self Care / Daily Living	○	○	○	○

2-LEGAL: JJ – JUVENILE JUSTICE

	0	1	2	3
Seriousness	○	○	○	○
History	○	○	○	○
Arrests	○	○	○	○
Planning	○	○	○	○
Community Safety	○	○	○	○
Legal Compliance	○	○	○	○
Peer Influences	○	○	○	○
Parental Influences	○	○	○	○
Environmental Influences	○	○	○	○

3-MEDICAL

	0	1	2	3
Life Threat	○	○	○	○
Chronicity	○	○	○	○
Diagnostic Complexity	○	○	○	○
Emotional Response	○	○	○	○
Impairment in Functioning	○	○	○	○
Treatment Involvement	○	○	○	○
Intensity of Treatment	○	○	○	○
Organizational Complexity	○	○	○	○

4-RUNAWAY

	0	1	2	3
Frequency of Running	○	○	○	○
Consistency of Destination	○	○	○	○
Planning	○	○	○	○
Safety of Destination	○	○	○	○
Involvement in Illegal Acts	○	○	○	○
Likelihood of Return on Own	○	○	○	○
Involvement of Others	○	○	○	○
Realistic Expectations	○	○	○	○

Wraparound Milwaukee

Out of Home Care Progress Report

Date of Report: 10/8/11
Youth's Name: Sample1, Client
Name of Facility: Wraparound Milwaukee

PLACEMENT HISTORY

Placement Date	*Discharge Date*	*Placement Type*	*Placement Name*

Service Month
September

In the past month, what needs from the POC have been addressed by in this placement?
Needs addressed from the POC have been...

What strengths/skills have been obtained to date through this youth's stay?
Strengths we are building on are...

How have safety concerns been addressed and what needs to be put into the crisis/safety plan to prevent further harm?
Safety concerns have been addressed by...

What methods of treatment have been utilized this past month to assist this youth in returning to his/her community?
Treatment methods we have used are...

List dates of home passes
09/07 to 09/11 09/28 to 09/30
09/14/ to 09/16
09/21 to 09/22

Recognizing that community passes are an integral part of youth's treatment, describe how the youth and family have been prepared for passes, and how you have assisted them in learning skills during and after passes to assist in successful transition from this placement.
We prepared for community passes by....

List any dates the youth was missing or on runaway status
none

For the youth: What do you need at this time to be successful in your home, school and community?
I need help with....

For the youth: What skills have you gained to date to assist you in being successful outside of your current placement?
I think I'm getting better at....

For the Parent/Guardian: What have you seen from your child recently that you would like to see more of?
We have seen positive changes in our child exhibited by...

For the Parent/Guardian: What do you need help or support with from your Child and Family Team to have your child return home?
We still need help with

Date discussed with youth and family
09/30/2011

Names of those present on that date.
Bob Jones, James Smith, Erim Habril, Jimmy Apna, Aunt Edna, Terry Newmann

Out of Home Care Progress Report

Date of Report: 10/8/11
Youth's Name: Sample1, Client
Name of Facility: Wraparound Milwaukee

Progress Report Prepared by: test test

Wraparound Milwaukee

J.S.O. Treatment Progress Report

This form is to be completed by the **Treatment Provider along with the Out-of-Home Care Progresss Report** for all youth receiving **Sexual Offense Specific Treatment**. A copy should be **forwarded to the youth's Probation Officer**. Thank you.

Date of Report: 5/1/11
Youth's Name: Sample1, Client
Name of Facility: Wraparound Milwaukee

Service Month

February

For the victim(s) - please describe how your work has addressed the victim's needs and what planning is taking place to insure safety during home passes and at the point of reunification.

test

Youth acknowledges harm done to victim(s) and the community.

No

Youth's parent(s) have been actively involved in family treatment aimed at preventing further abuse / exploitativeness.

No

If there have been intrafamilial victims, their needs have been identified and prioritized by the treatment team and their safety is at the core of treatment efforts within your program.

No

Youth and family have established a WRITTEN contract with treatment team providers, probation officer and others that specifies rules and expectations for insuring the SAFETY of all when youth is in the community (at home, in school, on the bus, etc.)

No

Youth has a personal history of having been maltreated sexually or otherwise.

No

If true, this history has been explored within treatment.

No

Youth's parent(s) (and intrafamilial survivors, as appropriate) have been educated regarding warning signs and risky situations and this is part of the family Safety Plan.

No

If true, these warning signs, risky situations and Safety Plans are written down and in the parent or supervising caretaker's, siblings' and youth's possession.

No

Has youth been exposed to a 'healthy sexuality' or 'healthy relationships' curriculum?

No

JSO Progress Report
Date of Report: 5/1/11
Youth's Name: Sample1, Client
Name of Facility: Wraparound Milwaukee

Report Prepared by: Bill Markut