

 WRAPAROUND MILWAUKEE Policy & Procedure	Date Issued: 9/9/08	Date Revised:	Section: ADMINISTRATION	Policy No: 049	Pages: 1 of 2 (1 Attachment)
	<input type="checkbox"/> Wraparound <input checked="" type="checkbox"/> Wraparound/REACH <input type="checkbox"/> FISS	Effective Date: 1/1/09	Subject: ENROLLMENT CRITERIA - REACH		

I. POLICY

It is the policy of Wraparound Milwaukee to follow specific guidelines/procedures in enrolling youth and families into the Wraparound Milwaukee REACH program.

The purpose of this policy is to clarify enrollment procedures and criteria, and to provide Care Coordinators with direction upon assignment of new youth and families.

II. ENROLLMENT CRITERIA

A. The Enrollment Criteria is as follows:

1. **Residency** - The parents, guardian or primary care giver of eligible children and youth will live in Milwaukee County.
2. **Age** - Eligible youth will be from birth through 18 years of age.
3. **Severe Emotional Disturbance** - Eligible youth will be determined to have severe emotional disturbance.
4. **Imminent Risk of Placement** - Eligible youth will be in an out-of-home placement or at imminent risk of admission to a psychiatric hospital or placement in a residential care center or juvenile correctional facility.
5. **Non-Nursing Home** - Eligible youth will not be residents of a nursing facility at the time of enrollment.
6. **Non-Psychiatric Hospital** - Eligible youth will not be residing in a psychiatric hospital or a psychiatric unit of a general hospital at the time of enrollment.

B. Definition of Severe Emotional Disturbance and Eligibility Criteria for Wraparound Milwaukee – REACH program.

The following definition will be used for Severe Emotional Disturbance. The disability must show evidence of points 1, 2, 3 and 4 below.

1. The disability must have persisted for six months and be expected to persist for a year or longer.
2. A condition of severe emotional disturbance as defined by: A mental or emotional disturbance as listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM IV). Youth must have a current (within the last year) DSM IV Diagnosis.
3. Functional Symptoms and Impairments – the youth must exhibit either a or b below.
 - a. Symptoms - the individual must have one of the following:
 - 1) Psychotic Symptoms - Serious mental illness (e.g., Schizophrenia characterized by defective or lost contact with reality, often with hallucinations or delusions).
 - 2) Danger to self, others and property as a result of emotional disturbance. The individual is self destructive (e.g., at risk for suicide, runaway, and/or at risk for causing injury to persons or significant damage to property).
 - b. Functional Impairment - in two of the following capacities (compared with expected developmental level):
 - 1) Functioning in Self Care - Impairment in self care is manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.

- 2) Functioning in the Community - Impairment in community function is manifested by a consistent lack of age appropriate behavioral controls, decision-making, judgement and value systems which results in potential involvement or involvement with the juvenile justice system.
 - 3) Functioning in Social Relationships - Impairment of social relationships is manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.
 - 4) Functioning in the Family - Impairment in family function is manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations which may result in removal from the family or its equivalent).
 - 5) Functioning at School/Work - Impairment in functioning at school is manifested by the inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others); meeting the definition of “child with exceptional educational needs” under ch. PI 11 and 115.76(3) Wis. Stats.; or impairment at work is the inability to be consistently employed at a self sustaining level (e.g., inability to conform to work schedule, poor relationships with supervisor and other workers, hostile behavior on the job).
4. The individual is receiving services from two or more of the following service systems.
- a. Mental Health Services.
 - b. Social Services.
 - c. Child Protective Services.
 - d. Juvenile Justice Services.
 - e. Special Education Services.

III. PROCEDURE

- A. REACH referrals are made by calling (414) 257-7607. The Enrollment Ccoordinator or designee will complete the Referral Form to determine eligibility (*see Attachment 1*). The demographic information is entered into Synthesis, Wraparound Milwaukee’s IT system, as a pending referral. If all criteria are met, but the youth does not have a current DSM IV diagnosis, he/she will be referred to the Mobile Urgent Treatment Team for a face-to-face assessment.
Note: A DSM IV diagnosis is considered current if it has been made within the past year.
- B. When it is determined that the youth is eligible and will be enrolled, the Enrollment Coordinator or designee will email the assignment to a Care Coordination Agency, with a copy to Families United and the Wraparound Finance Department.
- C. The Enrollment Coordinator or designee will place the original Referral Form in the REACH enrollment packet that is then given to the assigned Care Coordination Agency.
- D. A copy of the completed Referral Form is given to the Wraparound Milwaukee Finance Department to finalize the internal enrollment process.
- E. If it is determined that the youth does not meet eligibility, the Enrollment Coordinator or designee will provide family members with suggestions for alternative resources.
- F. Care Coordinators have 5 business days to make contact with the family and complete the enrollment process, which includes:
 1. Review all forms and Family Handbook with the family.
 2. Ensure that the family has transportation to the first available Family Orientation session.
 3. Ensure that the Consent Forms are signed by the parent/guardian and youth, if age 14 or older.

Reviewed & Approved by: Bruce Kamradt
Bruce Kamradt, Director



WRAPAROUND MILWAUKEE
REACH PROGRAM
REFERRAL FORM

Youth's Name _____

DOB: _____

SSN: _____

Initial Call Date: _____

School Placement: _____

SED Eligibility Verification (*The child must meet criteria as noted below*):

1) The youth must meet all four of the following:

- _____ Have emotional and behavioral problems that are severe in nature.
- _____ This disability has persisted for more than six (6) months.
- _____ This disability is expected to persist for a year or longer
- _____ The child is at risk for inpatient or out of home placement.

2) The youth must meet EITHER the criteria listed under "Symptoms" or those listed under "Functional Impairments":

Symptoms (*must have one*)

- _____ Psychotic symptoms
- _____ Suicidality
- _____ Violence

Functional Impairments (*must have two*)

- _____ Functioning in self care
- _____ Functioning in the community
- _____ Functioning in social relationships
- _____ Functioning in the family
- _____ Functioning at school / work

3) The youth must be involved in two or more systems (check below):

- | | |
|---------------------------------|---|
| _____ Mental Health | _____ Juvenile Justice |
| _____ Social Services | _____ Special Education or receiving supportive services from the school system (guidance counselor, social worker, psychologist, etc.) |
| _____ Child Protective Services | |

Diagnostic Information

Has the child been formally diagnosed? _____ Yes _____ No

If YES, is a copy of that document available? _____ Yes _____ No

(attach to Referral Form if available)

If child has not been diagnosed or if written diagnostic confirmation not available,

Date Referred to MUTT: _____

Date Seen by MUTT: _____

MUTT Staff: Attach copy of MUTT F-F Contact Form to this referral and return to Pauline Spencer.

DSM IV Diagnoses

Diagnosed by: _____ Diagnosis Date: _____

Axis I _____

Axis II _____

Axis III _____

Axis IV _____

Axis V _____

Demographic Information:

Youth's Address _____
City, State, Zip _____
Home Phone Number: _____

Youth Lives With (name(s)): _____
Relationship to youth: ___ Parent(s) ___ Other Relative(s)
___ Other (describe) _____

Mother's Name _____
Address (if different than youth) _____
City, State, Zip _____
Phone Number: Home: _____
Work: _____
Cell/Other: _____

Father's Name _____
Address (if different than youth) _____
City, State, Zip _____
Phone Number: Home: _____
Work: _____
Cell/Other: _____

Guardian Name _____
Address (if different than youth) _____
City, State, Zip _____
Phone Number: Home: _____
Work: _____
Cell/Other: _____

Educational Information

School Name: _____
Address: _____
City, State, Zip: _____
Contact Person: _____
Phone Number: _____

Has an IEP been done? ___ Yes ___ No ___ Pending
If yes, when? _____
(attach copy of IEP to this Referral Form)
Special Ed? ___ Yes ___ No
If yes, type(s) ___ ED ___ LD ___ CD ___ OHI ___ NA

Current Services and Supports in Place:

Gender (circle) Male Female

Ethnicity: African American Asian
 Bi-racial Caucasian
 Hispanic Native American
 Other _____

If youth/family primary language is NOT English, list family's primary language:

How did you hear about REACH? _____

Referred by: Name: _____

Phone Number(s): _____

Email Address: _____

Referral Source: Self/Family School MUTT MUTT-MPS
 (check one) Wrap Milw Provider FISS CAIS
 Pvt Inpt Hosp Families United BMCW School
 Safety Svcs Children's Court
 Other (describe) _____

(If referred through a school or MUTT-MPS, name of school) _____

What were you told or what do you already know about REACH? _____

If enrolled, what would you like to see different for your family? _____

What are you hoping we can accomplish together? _____

Reason for Referral: _____

Others in Household:

Name	Relationship	DOB or age	Referred/Enrolled in		
			REACH	Wrap	No
_____	_____	_____	REACH	Wrap	No
_____	_____	_____	REACH	Wrap	No
_____	_____	_____	REACH	Wrap	No
_____	_____	_____	REACH	Wrap	No
_____	_____	_____	REACH	Wrap	No
_____	_____	_____	REACH	Wrap	No
_____	_____	_____	REACH	Wrap	No

Insurance Information

Title 19 Number: _____ Page 3 of 5 _____

If family is also covered by private insurance:

Insurance Co. Name: _____

Policy Number: _____

Subscriber Name: _____

Other Notes

Mental Health History *(list current providers names/numbers; if more than three providers, please list on back)*

Provider Name _____

Provider Phone No.: _____

When Last Seen: _____

Provider Name _____

Provider Phone No.: _____

When Last Seen: _____

Provider Name _____

Provider Phone No.: _____

When Last Seen: _____

Current School Concerns / Recommendations

If the child is receiving any supports or services through the school system, describe below. If no services or supports are being provided through the school, write "none."
