Marion County
OREGON
Health & Human Services

Marion County WrapAround

Re: Information and referral packet for WrapAround

Thank you for your interest in the WrapAround Program. We have enclosed some important information for you to review, along with our intake referral packet to complete. Please return the referral packet, along with a copy of a recent Mental Health Assessment (MHA) that has been completed within the last year. Your mental health provider can assist you with this.

Please mail/drop off your completed referral packet and mental health assessment to 1654 @ctcpjw ? tc LC @JBE E Q_jc k * MP 751 . 3* d_v rm 3 . 1+14/+0560* mp c k _gj rm U P ? NMQ > am, k _pgm l ,mp, sq,

M l ac uc f_tc pcacgtcb rfc am k njcrcb pcdcpp_j n_aicr _l b k c l r_j f c_jrf _qqcqq k c l r* one of our Qualified Mental Health Professionals will be contacting you to begin our eligibility process to determine if the WrapAround Program matches the needs of your youth/family, or if other services and supports would be more appropriate.

Please let us know if you have any questions, or if we can be of any assistance. Our contact number is 503-576-4536. Thank you for your time and attention to this process. We look forward to working with you in support of your child.

Please return the following items:

- ☐ Completed Referral Packet
- ☐ Current Mental Health Assessment completed in the last year.
- ☐ OHP ID#

WRAPOS@co.marion.or.us
503-576-4536
3876 Beverly Ave NE, Building G, Salem, OR 97305

Incomplete packets will not be processed

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Marion County Health Department
YOUTH & FAMILY INFORMATION

Select Program: ☐ **WrapAround** ☐ **JWRAP** ☐ **Rapid Access Assessment**

Individual's Name: _____ Today's Date: _____

DOB: ____/____/____ SS#: _____ Race/Ethnicity: _____

OHP# _____
For JWRAP: Commercial Ins Provider: _____ Ins#: _____ ☐ No Insurance

Legal Sex: F ☐ M ☐ Identified Gender: _____

School Name: _____ Grade: _____ IEP/504 Plan: Yes ☐ No ☐

Parent Guardian Name: _____

Biological Mother: _____ Biological Father: _____

Address: _____

Best Contact #: (____) ____-_____ Is this: Home# ☐ Cell# ☐ Work# ☐

OK to leave message? Yes ☐ No ☐ Email: _____

Interpreter needed? Yes ☐ No ☐ Language: _____

CURRENT SERVICE PROVIDERS—Please list name and phone number of contact person

Agency/Provider	Name	Contact Number
Mental Health:		
Primary Care Physician:		
Medical Issues:		
Current Medications: Prescriber's Name:		
Juvenile Probation/OYA:		
Assigned Back-up:		
Juvenile Counselor:		
DHS Case Worker:		
Resource Parent:		
Alcohol/Drug Provider:		
Residential Provider:		
Other:		

CURRENT HOUSEHOLD MEMBERS

Name	Relationship	Age or Date of Birth	Grade/Occupation

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Consent For Treatment

I have read and/or had the following explained to me as part of my orientation to services with Marion County Health & Human Services (initial those that apply):

____ Rights and Responsibilities

____ Complaint and Grievance Procedure

____ Welcome Letter

If 18 years or older, initial those that apply

____ I was asked if I have completed an Advanced Directive

____ I was given information about a Declaration for Mental Health Treatment and was provided the opportunity to complete one if desired

I give Marion County Health and Human Services permission to provide me with evaluation and treatment services.

_____ _____

Signature (Individual or Guardian) Date

_____

Individual's Printed Name

☐ Refused to Sign	☐ Not Able to Sign
Circumstances for refusal/inability to sign:	

Revised 5/21

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NOTICE OF PRIVACY PRACTICES
Acknowledgement of Receipt

PLEASE REVIEW THIS ACKNOWLEDGEMENT CAREFULLY AND THEN SIGN AND DATE BELOW.

The Notice of Privacy Practices tells you how the Marion County Health Department may collect, use or disclose health information about you and tells you about your privacy rights. The Health Department is required to offer you a Notice of Privacy Practices by federal law.

I,

Client's Printed name

have been offered a copy of the Marion County Health Department's Notice of Privacy Practices and have had a chance to ask questions about how my health information will be collected, used and disclosed and how to access my privacy rights.

_____ _____

Client's Signature **Date**

_____ _____

Legal or Personal Representative of Client (if applicable) **Relationship**

This document is available in other languages and alternate formats that meet the guidelines for the Americans with Disabilities Act (ADA).
Contact your Service Provider, or call the general number for the Health Department at: Phone# 503-588-5357, or Fax# 503-364-6552.

Health Department Staff: *Please have this document completed and signed by the individual receiving the Notice of Privacy Practices.*

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FEE AGREEMENT

I understand that any fees assessed for services that I receive at Marion County New Solutions will be based on my income, the number of dependents in my family and on the Income Guidelines printed on the back of this form. My established payment for services, if any, will be based on the New Solutions charges also listed on the back of this form.

I understand that if I ha… insurance coverage, other than M… HP, Marion County New Solutions will bill my … any first and I may be held … y co-pays or amounts not cove… I understand that this … ly to those amounts not co… nce.

If my situation warra… es, I u… ake payment directly to Marion County New So… s in my situation that may impact my fee agreem… r.

I understand that if I do not follo… Program reserves the right to deny future service.

☐ Fee Reduction to _____

☐ Fee Waiver

Comments: _____

_____

Supervisor Signature: _____ _____

I understand and agree to t… conditions listed above regarding the fee … duction or waiver.

Signature: _____ Date: _____
Parent/Legal Guardian

MEDICAID/OHP COVERAGE

☒ Bill Medicaid/OHP Client Name: _____

I understand that I will not be charged any fees as long as I have Medicaid/OHP coverage nor be responsible for any charges not Medicaid/OHP.
I understand that if my Medicaid/OHP coverage is terminated, a new Fee Agreement will be completed to reassess my ability to pay and will be retroactive to the Medicaid/OHP termination date.
I agree to be responsible to report and changes in my Medicaid/OHP coverage to the New Solutions staff in a timely manner.

Parent/Legal Guardian Signature: _____ Date: _____

Revised 9/2021