Service Coordination and High Fidelity Wraparound Purpose

The purpose of Service Coordination and High Fidelity Wraparound through the Clermont County Family and Children First (FCF) Wraparound Program is to provide a neutral setting for families requiring services where their needs may not have been adequately addressed in traditional agency systems. Service Coordination and High Fidelity Wraparound are collaborative, coordinated, cross-system team-based planning processes implemented to address the needs of youth and families where those needs are multiple and complex. These processes build upon the strength of services in the community that are currently working for families, and when needed, propose new services, supports, and/or strategies to be added in order to address unmet needs.

The following is a list of values that are integral to the Service Coordination and High Fidelity Wraparound process, resulting in a more effective service delivery system:

- Services are delivered using a family-centered approach.
- Services are responsive to the cultural, racial and ethnic characteristics of the population being served.
- Service outcomes are evaluated.
- Available funding resources are fully utilized or integrated.
- Home and community supports are utilized as needed.
- Specialized treatment for difficult-to-serve populations and evidence-based treatments are encouraged.
- Duplicative or competing efforts among agencies are reduced or eliminated.
- Most importantly, families and youth are fully involved in decision-making and are offered with family advocacy and support options.

Eligibility Criteria

Any child, youth or young adult, age birth to 21, who has multi-systemic needs and whose needs have not been adequately addressed in traditional agency systems are eligible for the Clermont County FCF Wraparound Program. Multi-systemic needs include the following:

- Developmental Disabilities
- Child Neglect
- Drug and/or Alcohol
- Delinquent Charges
- Special Education
- Truancy
- Child Abuse
- Mental Health
- Unruly Charges
- Physical Health
- Poverty
CLARIFICATION FOR SPECIFIC POPULATIONS

As stated above any youth, age birth to 21, with multi-systemic needs is eligible for services. This also includes youth who are involved with the following agency systems:

- **Children’s Protective Services (CPS) (Youth in Custody or CPS Family Involvement)** - The Clermont County FCF Wraparound Program can be accessed for any youth with needs across multiple systems, including those youth whose families are involved with Children’s Protective Services.

- **Juvenile Justice System** – The Clermont County FCF Wraparound Program is available for any youth that is suspected or adjudicated unruly or delinquent, or considered to be truant and presents needs across multiple systems.

- **Early Intervention Service Coordination** – If a child is being served by the Clermont County FCF Wraparound Program and a referral is made to Early Intervention Service Coordination, upon determination of eligibility, the lead provider of service will be Early Intervention Service Coordination. For these children, the Clermont County FCF Wraparound Program will support and assist the Early Intervention Service Coordination team as needed. Also, the Clermont County FCF Wraparound Coordinator and Early Intervention Service Coordination Supervisor will meet quarterly to discuss collaboration efforts concerning children who will be aging out of Early Intervention Service Coordination on their third birthday. The purpose of these meetings will be to ease the transition of lead service agency from Early Intervention Service Coordination to the Clermont County FCF Wraparound Program for those families who will need additional services and supports moving forward.

Access to Wraparound Program

Referrals for the Clermont County FCF Wraparound Program may come from any agency serving a Clermont County family who has a child, youth or young adult, age birth to 21, in their home; or is working with a youth, age 21 or younger, whom is living independently. Referrals can also come from local community agencies (i.e. churches, Big Brothers Big Sisters, food pantries, etc.) or a family can self-refer.

Referral forms (attachment 1) are located on the Clermont County FCF website [www.clermontfcf.org](http://www.clermontfcf.org) and can be faxed to the Clermont County FCF Wraparound Coordinator at 513-732-7491 or emailed to rsorg@clermontcountyohio.gov. Referrals can also be taken over the phone by contacting the Wraparound Coordinator at 513-732-7862.

All referrals will be contacted within 1 business day of being received. Both the family and the referral source will receive notification from the Wraparound Coordinator that the referral has been processed, and, if applicable, who is the assigned Wraparound Facilitator. Once a family has been assigned to a Facilitator’s caseload, the Facilitator will contact the family within 2
business days to set up a face to face meeting in order to complete appropriate forms, begin gathering the family’s story, and discuss next steps. A follow-up face to face meeting will be scheduled with the family within 7 days of the initial meeting to begin implementing the appropriate level of service.

Levels of Service and Assessments

Clermont County FCF provides various levels of service within the Wraparound Program. Level of service provided to a family will be determined by the Ohio Child and Adolescent Needs and Strengths (CANS) assessment (attachment 2) (http://praedfoundation.org). This tool will be utilized by a trained Wraparound Facilitator after the face to face meeting with a family. It is the goal of Clermont County FCF to always offer families the most appropriate, least intensive level of service first; then, work up to more intensive levels of service and interventions as needed.

The levels of service provided to families include:

- **Information and Referral** – Ohio CANS score of 0 - 50
- **Service Coordination** – Ohio CANS score of 51 – 100
- **High Fidelity Wraparound** – Ohio CANS score of 101+

The Ohio CANS will be conducted every 90 days in order to continually evaluate and modify the most appropriate level of service being provided. Also, the Ohio CANS will be used to track outcome measures, such as an increase in Child’s Strengths and a decrease in Child Behavioral/Emotional Needs, for families involved in the Wraparound Program.

**Information and Referral**

Information and Referral will be offered to families who score a 0 – 50 on the Ohio CANS. This level of service will include a referral (if desired) to a Parent Peer Support Partner (PSP) from Families Connected, a parent-led advocacy and support organization, as well as, information and referrals to various other community resources that are available to help meet the needs discussed during the Facilitator’s initial face to face meeting with a family. In addition, the Facilitator will offer “follow-up” contacts for the proceeding 90 days in order to offer additional supports and help determine if the information and referrals are meeting the family’s needs. At the end of 90 days, another CANS assessment will take place to conclude if the level of service needs to be moved to Service Coordination, or if the family is ready to be dismissed from the program. At any point during the process a family can be dismissed from the program upon request.

**Service Coordination**

Service Coordination will be offered to families who score a 51 – 100 on the Ohio CANS. Service Coordination is a broad-based, neutrally positioned, youth and family-driven, cross-system
(team) planning process by which previously identified and existing resources and supports are coordinated to determine the least restrictive plan of success for youth with complex needs. During the Service Coordination process a trained Facilitator will work with the team, which will include the family and pre-existing service providers, to create a plan that focuses on the following areas in order to help foster success for a youth and family:

1. Formatting the alignment of services provided.
2. Ordering the sequence of services provided.
3. Eliminating the duplication of services provided.
4. Monitoring the depth/Intensity of services provided.

In addition to team facilitation, families will be offered a referral for a PSP from Families Connected, follow-up phone calls and contact from their assigned Facilitator, and face to face meetings as needed. Also, as deemed appropriate, families may be eligible to access Family and Children First Pooled Funds.

High Fidelity Wraparound

High Fidelity Wraparound will be offered to families who score a 101+ on the Ohio CANS. High Fidelity Wraparound is a specific evidence-based intensive planning and facilitation process, utilizing a comprehensive team to develop a uniquely designed helping plan based on the youth and family’s unmet needs, and is inclusive of uniquely designed resources linked to youth and family strengths. During the High Fidelity Wraparound process, a trained Facilitator will work with a team, which will include the family, extended family and friends, community supports and formal services, in order to create a plan that will meet a family’s unmet needs. The goal of this process is to:

1. Change the way people look at the family.
2. Change the way people look at the problem.
3. Change what help may look like for the family.

The purpose of High Fidelity Wraparound is not the elimination or ending of formal supports and services, but rather the increased capacity of a family and those around them to get their needs met without the reliance on an on-going intensive team-based planning and adaptation process.

In addition to team facilitation, families will be offered a referral for a PSP from Families Connected, follow-up phone calls and contact from their assigned Facilitator, and face to face meetings as needed. Also, as deemed appropriate, families may be eligible for Pressley Ridge In Home Supports and access to Family and Children First Pooled Funds.
On-Going Family Team Meetings

Families who are receiving Service Coordination or High Fidelity Wraparound will work with their assigned Facilitator in the development of their family team. Family teams are a group of individuals (who the family approves of) that work with the Wraparound Facilitator and the family in creating and implementing a plan to meet the family's needs. Family teams can include paid professionals, community members, Peer Support Partners, parent advocates, extended family members, friends, or any individual that a family would like to participate.

Potential family team members will be invited to participate in the Service Coordination or High Fidelity Wraparound process by the assigned Facilitator. The Facilitator will prep both team members and the family for the initial team meeting, which will be scheduled within 30 calendar days from the initial face to face meeting with the family.

The intent of family team meetings is the creation and monitoring of a family's individualized Plan of Care (attachment 3). During team meetings, a trained Facilitator will lead the family and team in an appropriate discussion that coincides with the level of care being provided. After an initial family team meeting, on-going family team meetings will be used to monitor and update the Plan of Care.

On-going family team meetings will take place every 1 to 6 weeks depending on the needs of the family and scheduling preferences of the family and team members. The Wraparound Facilitator will send reminders for all upcoming team meetings to team members, via email or phone, no sooner than 2 business days before the meeting is to take place. Also, the Facilitator will work with the family to add new team members, as needed, throughout the process. Finally, all notes from family team meetings will be sent out to all team members within 3 business days of a meeting.

At any point families can request additional or emergency team meetings by contacting their assigned Wraparound Facilitator.

Family Team Meetings for Youth at Risk of Out-of-Home Placement

At any point in time, a service agency, community agency, or family can request an emergency meeting for a youth is who is at risk of out-of-home placement. This also includes youth who are not enrolled in the Wraparound Program. These meetings will be facilitated by either the Wraparound Coordinator or Clermont County FCF Director, for the purpose of exploring whether or not all less restrictive options have been exhausted within Clermont County and the surrounding areas.

Clermont County FCF does not place or fund children in out-of-home placements. The intent of the Clermont County FCF Wraparound Program is to safely maintain youth in their family home, and the decision to place a youth outside of their home is the sole decision of Clerk County Children’s Protective Services or Juvenile Court. However, if the decision is made for a youth to
have an out-of-home placement, a Wraparound Facilitator can be assigned to the family and team, if desired, to begin planning for community supports for the family during placement and for the child’s return to the community.

If an emergency placement is made for a youth who is enrolled in the Wraparound Program, the assigned Facilitator will work with the family and team to schedule an emergency family team meeting within 10 business days of the placement. The intent of this meeting will be to plan for community supports for the family and to begin planning for the child’s return to the community.

The Clermont County FCF Wraparound Program and its staff cannot recommend out-of-home placement for any youth. If a family is interested in exploring out-of-home placement as an option for their youth, the assigned Facilitator will recommend to the family to explore this with Children’s Protective Services, Juvenile Court, or other service providers. In addition, any recommendations and plans developed by Clermont County FCF and the Wraparound Program will not override decisions and policies of Juvenile Court, Children’s Protective Services or Board of Developmental Disabilities (BDD).

Dismissal from Program

The goal of the Clermont County FCF Wraparound Program is to help families move from crisis to stable, and to help the families and the community develop skills to maintain stability for the long-term. Stability is determined by the following factors:

1. **Ohio CANS Assessments** – Every 90 days the assigned Facilitator will complete a new Ohio CANS for each family enrolled in the program. Progress documented by the Ohio CANS will be used to help determine whether a family has reached stable functioning.

2. **Plan of Care** – Each family involved in either Service Coordination or High Fidelity Wraparound will have a Plan of Care that will focus on helping a family accomplish goals and/or meeting unmet needs. Outcome measures will be included in every Plan of Care to help determine when goals and needs are met. Results of outcome measures documented in the Plan of Care will be used to help determine whether a family has reached stable functioning.

3. **Family and/or Team Self-Report** – A family or entire family team can report at any time to the assigned Wraparound Facilitator that they believe they have reached stable functioning.

All of these factors will be taken into consideration if/when the Facilitator begins having a conversation with the family and team about preparing for the next level of care after the Wraparound Program. If appropriate, the Facilitator will work with the family and team to plan around future hopes and concerns they may have. Also, the Facilitator will work to create a set of documents that summarizes the progress made while participating in the Wraparound

pg. 6
Program, all Plans of Care, lists of future resources, self-care tools and letters of introduction that families can present to future care-providers.

Families who have been dismissed from the Wraparound Program will be documented an Electronic Health Record (EHR) (the Wraparound database) as being dismissed for one of following reasons:

- Referral rescinded
- Family moved out of service area
- Family did not engage in services
- Family no longer wanted to continue
- Family successfully met all goals
- Family successfully met some goals

The Clermont County FCF Wraparound Program is voluntary, so at any point while enrolled, a family can request to be dismissed from the program.

Crisis Planning and Safety Programming

The Clermont County FCF Wraparound Program will look at crisis planning and safety programming for families as two separate components to a family’s overall Plan of Care.

_Crisis Planning_

The purpose of crisis planning is to help families and teams better manage single events that can be anticipated and are unpleasant. A crisis response plan, detailing options for preventing a known crisis and responses by those supporting the youth and family through such an event, will be developed based on family need and preference.

For those families and teams, the assigned Wraparound Facilitator will work with the family and team in the development of a plan that is both proactive and reactive. The Facilitator will work with the team on practicing the crisis plan in order to test its validity. In the event of an actual crisis where a crisis plan is implemented, the Facilitator will call a family team meeting to discuss the effectiveness of the plan and restructure it as needed.

_Safety Programming_

The purpose of safety programming is to help reduce the overall likelihood and impact of risk events in families’ lives. A trained Facilitator will use the Risk Assessment Matrix (attachment 4) (www.paperboat.com) to determine if safety programming is a necessary component of a family’s Plan of Care. If appropriate the Facilitator will lead the family and team in a conversation that focuses on increasing protective factors in the family’s life and not on managing or containing behaviors.
The protective factors that will be focused on are:

1. **Community Building** – Discover who cares about the youth and family and find ways for those individuals to become involved in their lives.
2. **Confidence Building** – Discuss who was harmed and how to address it.
3. **Capacity Building** – Decide what skills need to be developed amongst the family, team and community.
4. **Context Building** – Determine what could have been done differently.

Conversations and planning around these factors will be interwoven throughout family team meetings and will be included in a family’s Plan of Care.

**Program Monitoring**

Quality, consistency and fidelity of the program will be monitored by the Wraparound Coordinator. Individual supervision will be held for each Facilitator on a weekly basis, with group supervision taking place once a month. Shadowing of family team meetings will take place on a regular basis. The Wraparound Coordinator will review families’ Plans of Care, Ohio CANS assessments and families’ team meeting notes to determine whether a Facilitator is delivering consistent, high quality service to all families on his/her case load.

*Reports to Family and Children First Council*

All families enrolled in the Clermont County FCF Wraparound Program will be subject to data collection while enrolled. Data will be collected through the EHR data system, satisfaction surveys (attachment 5), Ohio CANS, WFI-EZ (attachment 6) (when applicable), and parent self-report. This de-identified information will be shared with the Clermont County Family and Children First Council, and various other system partners, on a regular basis. Data reported will include:

- **Process Outcomes** – Number of new referrals and referral sources, total number of families served, number of families dismissed from program and reason for dismissal, average length of enrollment, etc.
- **Demographics** – average age of youth served, gender, race and ethnicity, TANF eligibility, local school district, special education, etc.
- **Needs Assessed and Services Accessed** – Needs present at intake and services accessed while enrolled
- **Family Self-Report** – results of satisfaction surveys at end of enrollment, summaries of success stories, etc.

Information collected and reported to the Clermont County Family and Children First Council will be used to inform the Council of possible “gaps” in county services, update the Council of reoccurring or new needs arising in the community, and offer Council possible strategies to help
fill service gaps and meet the community’s needs. This information will also be used to inform the decision making process and collaboration efforts outside of Council.

**Monitoring of Out-of-Home Placements**

All youth who are in out-of-home placements by Juvenile Court, Children’s Protective Services or Board of Developmental Disabilities, for the purpose of residential treatment, will be monitored by the Clermont County FCF Director through Residential Treatment Reviews. The purpose of these reviews is to work with the assigned Probation Officer, Caseworker or Service and Support Administrator, and their Supervisors and Directors to monitor the progress of residential treatment and work on developing strategies to help transition a youth back into the community as soon as possible. The Clermont County Level of Care (LOC) tool will be utilized during these reviews to help determine if residential placement is the most therapeutic course of action, and to help determine when step down from a residential treatment facility should be discussed.

The guardian of a youth who is Medicaid eligible, and has been placed at a residential treatment facility for 90+ days, will be offered the option of participating in HOME Choice through Clermont County FCF to support the transition back into the community. For more information about the HOME Choice program and eligibility requirements, please consult the HOME Choice Transition Coordinator Manual (attachment 7).

The FCF Director will report to Council the total number of youth in residential placement, total number of youth enrolled in HOME Choice, and any barriers that may be preventing a youth from returning to the community.

**Confidentiality**

All information gathered by Clermont County FCF Wraparound Program pertaining to enrolled families is confidential and all communication will be compliant with HIPAA laws and policies. All families will be required to complete a Release of Information (attachment 8) form during their initial face to face meeting with their assigned Wraparound Facilitator. The Facilitator will use the Release of Information to guide their communication with team members and service providers while the family is enrolled in the program. Also, all family team meetings will begin with a sign-in sheet (attachment 9) that prohibits a team member in attendance from sharing confidential information outside of team meetings unless they have an appropriate Release of Information from the family.

If needed, families can give written consent, via email, to allow a Facilitator to release personal information to possible team members and other service agencies. This written consent will be uploaded into Fidelity EHR. It will be the responsibility of the Facilitator to update the Release of Information at the following face to face meeting with the family.
Dispute Resolution

Please see attachment 10.

Community Awareness

Clermont County FCF makes every effort to ensure that the community is aware of FCF, the FCF Wraparound Program, and the services and supports available to children and their families.

- FCF participates in the county fair and has a booth at various activities around the county (i.e. readiness fairs).
- FCF maintains a website listing local resources, Council information, and details regarding the referral process.
- FCF has developed a local resource guide and school directory for assistance in locating appropriate resources/services. The directories are available on the FCF website and are provided at any time upon families requests.
- FCF does presentations to school mental health specialists, superintendents, and Children’s Protective Services, BDD and Juvenile Court staff to inform them of FCF, the Wraparound Program, and services/supports available, as well as providing trainings to staff regarding changes or updates to the service coordination mechanism.
- FCF participates in various groups to inform the community of FCF, Wraparound, and services/supports available. Examples are the Head Start Policy Council, Coalition for a Drug Free Clermont County, and the Regional Autism Advisory Council.
- Families Connected, Inc. is an active member of Council. As Families Connected assists parents with many different needs, their knowledge of Council enables them to discuss FCF and Wraparound with families.
- The Service Coordination Mechanism is available on the FCF website, and is provided in hard copy form at any time upon families’ requests.
# Clermont County Community Wraparound Referral Packet

Date: ____________________

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<tr>
<th>Identified Youth's Name</th>
<th>Date of Birth</th>
<th>Adopted Y or N</th>
<th>School</th>
<th>Grade</th>
<th>Ethnicity/Race</th>
<th>Gender</th>
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**Education Placement (Check One)**

- Regular School
- Home Instruction
- PH
- Alternative School
- Home Schooled
- Hearing Impaired
- Dropped Out

**Does youth have Medicaid?** □ Yes □ No

**Service Requested (leave blank if uncertain):**

- □ High Fidelity Wraparound
- □ Service Coordination
- □ HOME Choice - Medicaid # (if selecting HOME Choice) ________________

**Parties Involved:**

- □ Children with Medical Handicaps program
- □ Board of Developmental Disabilities
- □ Children's Services
- □ Help Me Grow
- □ Juvenile Court-Diversion
- □ Juvenile Court-Probation
- □ Mental Health
- □ School
- □ Substance Use
- □ Other ________________

**Is the youth on an IEP?** □ Yes □ No

**Preferred Language:** ____________________

**What do you hope to accomplish by making a referral to Wraparound/Service Coordination?**

Rank all that apply in order of importance, 1 being the highest.

- □ Coordination of services
- □ Develop/access supports for family
- □ Improved family functioning
- □ Help in managing behaviors
- □ Skill-building
- □ Help with school issues
- □ Appropriate treatment for youth
- □ Linkage to resources
- □ Safety/crisis planning
- □ Other ____________________

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<th>Guardian Name:</th>
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<td>Relation:</td>
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**Is youth currently out of the home (hospital, detention, treatment facility)?** □ Yes □ No

If yes, complete the following:

**Placement:**

**Address:**

**City:**

**State:**

**Zip:**

**Phone:** ( )

**Email:**

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Other household members: | DOB | Relationship | Adopted Y or N | School | Grade |
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Referral by: | Agency: | Phone: | Email: |
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Current Personal or Community Supports and Service Providers
(Juvenile Court, Dev. Disabilities, Schools, Mental Health, Children Services, Churches, Family, Friends, Scouts, etc.)

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<th>NAME</th>
<th>AGENCY/ORGANIZATION (if applicable)</th>
<th>ROLE-RELATIONSHIP</th>
<th>PHONE (ext)</th>
<th>EMAIL ADDRESS</th>
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Mental Health Diagnosis: ____________________________________________

Current Medications: ______________________________________________

Prescribed by: Dr. ________________________________________________

Primary Physician's Name: _________________________________________

Check if History of Abuse: ☐ Physical ☐ Sexual ☐ Neglect ☐ Victimization
Reports of sexual and/or abuse of the youth, past or present. (Professional must follow duty to report mandate if this event has not already been reported)

Which if any of the following systems has your child been involved with in the past 12 months?

☐ JFS/Children’s Services
☐ Mental Health Treatment
☐ Substance Use Treatment
☐ Developmental Disabilities
☐ Health Care
☐ Special and/or Alt. Education
☐ Juvenile Ct/ Law Enforcement

Could you briefly explain their involvement?

Check if the court has found the youth: ☐ Unruly ☐ Delinquent (criminal offense if an adult)
Presenting Risks that occurred in the PAST 30 DAYS.

**Behavior:**

- Suicidal Ideation: Youth states, talks, or thinks about hurting or killing self.
- Suicidal Gestures: Youth engages in non-life threatening behavior, concurrent with thoughts and/or talk about suicide.
- Suicide Attempt: Serious life threatening attempt with clear intent and desire to commit suicide. (attempted hanging; potentially lethal overdose; involvement of a gun)
- Self-Injurious Behaviors: Self-harming behaviors that are not life threatening and may be of a chronic nature such as: cutting, head banging, ingestion or insertion of objects.
- Violent Behaviors: Behaviors that cause serious harm, injury, or damage to people, property or animals. Example: domestic violence, animal torture, extensive property damage with intent to harm.
- Aggressive Behaviors (Towards people or animals etc): Youth demonstrates behaviors that are potentially dangerous or harmful to people or animals, without serious damage. Examples: Bullying, pushing.
- Verbal or Written Threats to Others: Youth states or writes threats of harm toward people, places, or things.
- Availability of Weapons: Youth has access to obtaining weapons through self, family, friends, or neighbors.
- Impulsive Behaviors: Youth exhibits behaviors without thought or planning that are potentially dangerous or harmful to self or others.
- Limited Ability to Control Anger: Youth demonstrates difficulty in managing emotions with limited abilities in controlling or managing his or her anger.
- Runaway: History or recent episodes of youth being absent from home without the permission or the caregiver’s knowledge of the youth’s whereabouts.
- Negative peer involvement or gang activity: Peer or gang involvement that results in negative behaviors by the youth.
- Chargeable Sex Offense: Youth has admitted to or has been charged with a sexual offense, or is part of a current sexual offense investigation.
- Prejudicial thinking: Youth identifies or espouses hate group thinking or philosophy. Evidence of prejudicial thinking or views pose a potential risk to others or property.
- Known/Suspected Criminal Activity: Youth is suspected of, or admitted to, being involved in activities that are chargeable offenses; has current pending court charges for criminal behavior(s); or the youth has been found “guilty” of criminal charges.
- High Risk Sexual Behavior: Youth has a recent or current history of sexually active behaviors without regard for personal safety or negative outcomes.
- Youth uses drugs or alcohol: Youth admits to use of alcohol or drugs, or drug screen for youth tests positive.
- Anorexia or Bulimia: Youth exhibits or is known to have clear patterns of bingeing/purging or abnormal amounts of limiting food intake with significant weight loss which concerns the parent or caregiver.
- Anxiety: Youth has intense anxiety, avoidance, obsessions, compulsions, fearfulness or persistent and excessive worry.
- Fire Setting Behaviors: Fascination with fire, play with matches or objects that have the potential to set fire and harm self or others. Previous reports of fire setting or a pattern of concerns related to fire.
Family/Caregiver/Environmental

- Caregiver with chronic/acute mental illness, developmental delay, or mental retardation: Caregiver has significant mental illness, developmental disability, or mental retardation where the disability compromises or limits his or her ability to care for the needs of youth and family. Caregiver's disability may limit their ability to monitor and supervise the youth.

- Caregiver with Drug or Alcohol Problem: Caregiver has a substance abuse problem which compromises or limits his or her ability to care for the needs of youth and family. Such use may limit their ability to monitor and supervise the youth.

- Caregiver with severe chronic illness: Caregiver has significant chronic illness that is debilitating and limits his or her ability to care for the needs of youth and family. Caregiver's illness may limit their ability to monitor and supervise the youth.

- Resides in high crime neighborhood: Youth and/or caretaker report that neighborhood crime/violence is at a level that is a potential safety issue for the youth and family. Normal daily activity and functioning is limited because of these safety concerns.

- Unrestricted internet access: Evidence of access and/or exposure to internet sites that pose a risk or danger to the youth; online interactions without sufficient monitoring or computer safeguards; and/or unlimited access to internet usage.

- Lack of caregiver supervision or behaviors that overwhelm caregiver resources: Insufficient adult monitoring and supervision, given the youth's age and/or disability, and without regard for safety or negative outcomes or such severe behavior caregiver cannot adequately address safety of youth.

- Current Placement Suspected Child Abuse: Abuse is suspected or alleged by current caregiver/guardian, which places the child at imminent risk or danger.

- Acute Family Crisis: Family is experiencing a crisis, family defined, that restricts or limits their resources or abilities to care for or supervise youth's safety or behaviors.

- Family Conflict: Verbal or physical family disagreements that pose a real or potential risk or safety concern to the youth and/or family.

- Poverty, Youth's Lack of Stable Residence/Homelessness: Youth does not have consistent ongoing housing, which may lead to additional instability and safety concerns or caregiver lacks resources to meet basic needs of youth.

Emotional Disturbances

- Limited Developmental Capacity to Maintain Personal Safety: Youth's personal safety is at risk due to his or her inability to maintain personal safety and care for self independently.

- Severe social impairment: Youth has significant social interaction problems or misperceives social situations and youth's behavior causes safety issues for self or others, and or youth has strong reaction to their environment or sensory input that interferes with normal functioning.

- Mood difficulties: Youth or parents state that the youth appears to be depressed, withdrawn, and/or shows marked diminished interest or pleasure in activities and/or period of abnormally and persistently elevated or irritable mood.

- Hears voices or sees things: Youth states hearing voices or seeing things that are not based in reality.

School

- Suspended, Expelled, or Dropped Out of School: Youth has multiple suspensions from school that places him or her at risk of expulsion, is expelled from school, or has dropped out of school.

- Held Back/Behind in Grade: Youth has been retained one or more years in school.
- Truancy: Admitted or reported failure to attend school on a regular basis, which may result in legal action.

- Emotional or Educational Disabilities: Youth has been assessed to have a serious emotional, developmental, and/or learning disability,

*Adapted from Stark County Family Council
Community Wraparound

Child's Strengths: __________________________________________________________

________________________________________________________________________

Barriers to Treatment: _____________________________________________________

________________________________________________________________________

What is the goal of this referral? What would you like to accomplish?

________________________________________________________________________

________________________________________________________________________

For FCF office use only

☐ Accepted ☐ Declined

Assigned to: ______________________________________________________________
## Life Domain Functioning (Please rate the highest level from the past 30 days.)

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## Developmental Needs Module (Please rate the highest level in the past 30 days)  
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*If a score of 2 or 3 is provided, please complete the subset module questions if available*
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Relationship Permanence (This rating refers to the stability of significant relationships in the child or youth’s life. This likely includes family members but may also include other individuals.)

Resiliency (This rating should be based on the individual’s ability to identify and use internal strengths in managing their lives.)

Resourcefulness (This rating should be based on the individual’s ability to identify and use external/environmental strengths in managing their lives.)

Acculturation (Please rate the highest level from the past 30 days.)

*If a score of 2 or 3 is provided, please complete the subset module questions if available.
2= ACT to address need 3= ACT immediately, intensely

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Language (This item includes both spoken and sign language)

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Identity (Cultural Identity refers to the child’s view of his/herself as belonging to a specific cultural group. This cultural group may be defined by a number of factors including race, religion, ethnicity, geography or lifestyle.)

☐ ☐ ☐ ☐ ☐ Click or tap here to enter text.

Ritual (Cultural rituals are activities and traditions that are culturally including the celebration of culturally specific holidays such as Kwanza, Cinco de Mayo, etc. Rituals also may include daily activities that are culturally specific (e.g. praying toward Mecca at specific times, eating a specific diet, access to media.)

☐ ☐ ☐ ☐ ☐ Click or tap here to enter text.

Cultural Stress (Cultural stress refers to experiences and feelings of discomfort and/or distress arising from friction (real or perceived) between an individual’s own cultural identity and the predominant culture in which he/she lives. This need reflects things such as racism, discrimination, or harassment because of sexual orientation or appearance or background.)

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**Planned Permanency Caregiver Needs and Strengths (Please rate the highest level from the past 30 days.)**

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0= no evidence of need 1= monitor, collect more info 2= ACT to address need 3= ACT immediately, intensely

**Score:** 0

Supervision

☐ ☐ ☐ ☐ ☐ Click or tap here to enter text.

Involvement with Care

☐ ☐ ☐ ☐ ☐ Click or tap here to enter text.

Knowledge

☐ ☐ ☐ ☐ ☐ Click or tap here to enter text.

Organization

☐ ☐ ☐ ☐ ☐ Click or tap here to enter text.

*If a score of 2 or 3 is provided, please complete the subset module questions if available*
| Social Resources | ☐ ☐ ☐ ☐ ☐ | Click or tap here to enter text. |
| Residential Stability | ☐ ☐ ☐ ☐ ☐ | Click or tap here to enter text. |
| Physical Health | ☐ ☐ ☐ ☐ ☐ | Click or tap here to enter text. |
| Mental Health | ☐ ☐ ☐ ☐ ☐ | Click or tap here to enter text. |
| Substance Abuse | ☐ ☐ ☐ ☐ ☐ | Click or tap here to enter text. |
| Developmental | ☐ ☐ ☐ ☐ ☐ | Click or tap here to enter text. |
| Safety | ☐ ☐ ☐ ☐ ☐ | Click or tap here to enter text. |

**Child Behavioral/Emotional Needs (Please rate the highest level from the past 30 days.)**

Score 0

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<td>Impulsivity/Hyperactivity</td>
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| Adjustment to Trauma | ☐ | ☐ | ☐ | ☐ | ☐ | Click or tap here to enter text. |

**Trauma Module (Please rate within the lifetime.)**

Score: 0

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<td>3= ACT immediately, intensely</td>
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*If a score of 2 or 3 is provided, please complete the subset module questions if available*
### Trauma Due to Sexual Abuse Module

**Score:** 0

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### Emotional Closeness to Perpetrator

- [ ] [ ] [ ] [ ] [ ]

### Frequency of Abuse

- [ ] [ ] [ ] [ ] [ ]

### Duration

- [ ] [ ] [ ] [ ] [ ]

### Force

- [ ] [ ] [ ] [ ] [ ]

### Reaction to Disclosure

- [ ] [ ] [ ] [ ] [ ]

### Physical Abuse

- [ ] [ ] [ ] [ ] [ ]

### Emotional Abuse

- [ ] [ ] [ ] [ ] [ ]

### Medical Trauma

- [ ] [ ] [ ] [ ] [ ]

### Natural Disaster

- [ ] [ ] [ ] [ ] [ ]

### Witness to Family Violence

- [ ] [ ] [ ] [ ] [ ]

### Witness to Community Violence

- [ ] [ ] [ ] [ ] [ ]

### Witness/Victim to Criminal Activity

- [ ] [ ] [ ] [ ] [ ]

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### Trauma Adjustment Module (Please rate highest level from the past 30 days.)

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### Affect Regulation

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*If a score of 2 or 3 is provided, please complete the subset module questions if available*
### Intrusions
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### Attachment
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### Dissociation
- [ ]
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### Anger Control
- [ ]
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### Substance Use
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**Substance Use Module (Please rate highest level from the past 30 days.)**

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### Severity of Use
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### Duration of Use
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### Stages of Recovery
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### Peer Influences
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### Parental Influences
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### Environmental Influences
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### Child Risk Behaviors (Please rate the highest level from the past 30 days.)

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### Suicide Risk
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### Self-Mutilation
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*If a score of 2 or 3 is provided, please complete the subset module questions if available*
Other Self-Harm

Danger to Others

**Violence Module – Historical Risk Factors**

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<td>Witness to Environmental Violence</td>
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**Violence Module – Emotional/Behavioral Risks**

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**Violence Module – Resiliency Factors**

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<td><strong>Commitment to Self-Control</strong></td>
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<td><strong>Treatment Involvement</strong></td>
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<td><strong>Sexual Aggression</strong></td>
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<td><strong>Relationship</strong> (Please rate the most recent episode of sexual behavior)</td>
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<td><strong>Physical Force/Threat</strong> (Please rate the highest level from the most recent episode of sexual behavior.)</td>
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<td><strong>Planning</strong> (Please rate the highest level from the most recent episode of sexual behavior.)</td>
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<td><strong>Age Differential</strong> (Please rate the highest level from the most recent episode of sexual behavior.)</td>
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<td><strong>Type of Sex Act</strong> (Please rate the highest level from the most recent episode of sexual behavior.)</td>
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*If a score of 2 or 3 is provided, please complete the subset module questions if available.*
Response to Accusation (Please rate the highest level from the past 30 days.)

☐ ☐ ☐ ☐ ☐ Click or tap here to enter text.

Temporal Consistency

☐ ☐ ☐ ☐ ☐ Click or tap here to enter text.

History of Sexually Aggressive Behavior (Toward others.)

☐ ☐ ☐ ☐ ☐ Click or tap here to enter text.

Severity of Sexual Abuse

☐ ☐ ☐ ☐ ☐ Click or tap here to enter text.

Prior Treatment

☐ ☐ ☐ ☐ ☐ Click or tap here to enter text.

Runaway

☐ ☐ ☐ ☐ ☐ Click or tap here to enter text.

Runaway Module

Score: 0

0= no evidence of need
1= monitor, collect more info
2= ACT to address need
3= ACT immediately, intensely

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2*</th>
<th>3*</th>
<th>TS</th>
<th>Notes</th>
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Frequency of Running

☐ ☐ ☐ ☐ ☐ Click or tap here to enter text.

Consistency of Destination

☐ ☐ ☐ ☐ ☐ Click or tap here to enter text.

Safety of Destination

☐ ☐ ☐ ☐ ☐ Click or tap here to enter text.

Involvement in Illegal Activities

☐ ☐ ☐ ☐ ☐ Click or tap here to enter text.

Likelihood of Return on Own

☐ ☐ ☐ ☐ ☐ Click or tap here to enter text.

Involvement with Others

☐ ☐ ☐ ☐ ☐ Click or tap here to enter text.

Realistic Expectations

☐ ☐ ☐ ☐ ☐ Click or tap here to enter text.

Planning

☐ ☐ ☐ ☐ ☐ Click or tap here to enter text.

Delinquent Behavior

☐ ☐ ☐ ☐ ☐ Click or tap here to enter text.

Juvenile Justice Module

Score: 0

0= no evidence of need
1= monitor, collect more info
2= ACT to address need
3= ACT immediately, intensely

*If a score of 2 or 3 is provided, please complete the subset module questions if available*
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<td><strong>Seriousness</strong></td>
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<tr>
<td><strong>History</strong></td>
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<td><strong>Community Safety</strong></td>
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<td><strong>Peer Influences</strong></td>
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<td><strong>Parental Criminal Behavior</strong></td>
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*If a score of 2 or 3 is provided, please complete the subset module questions if available*
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<th>TS</th>
<th>Notes</th>
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Environmental Influences (Please rate the environment around the youth's living situation.)

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<th>Judgement</th>
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**Fire Setting Module**

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<th>Score: 0</th>
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<tbody>
<tr>
<td>0= no evidence of need</td>
<td>1= monitor, collect more info</td>
<td>2= ACT to address need</td>
<td>3= ACT immediately, intensely</td>
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Seriousness (Please rate most recent incident.)

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Planning (Please rate most recent incident.)

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Use of Accelerants (Please rate most recent incident.)

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Intention to Harm (Please rate most recent incident.)

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Community Safety (Please rate highest level in the past 30 days.)

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Response to Accusation (Please rate highest level in the past 30 days.)

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Remorse (Please rate highest level in the past 30 days.)

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*If a score of 2 or 3 is provided, please complete the subset module questions if available*
Likelihood of Future Fire Setting (Please rate highest level in the past 30 days.)

☐  ☐  ☐  ☐  Click or tap here to enter text.

Social Behavior  ☐  ☐  ☐  ☐  Click or tap here to enter text.

*If a score of 2 or 3 is provided, please complete the subset module questions if available
About the Family Service Plan

Start Date: 
Last Date Updated: 
Version: Status: Type: Date of CFT: 

About the Youth

Address: Details: 

About the Parent/Guardian

Name: Details: Relationship: Other Family Email: -- 
Address: 

Team Strengths

No Team Member records were found! 

Team Abilities

No Team Member records were found! 

Team Preferences

No Team Member records were found! 

Family Level Of Engagement
Plan Of Care

Youth Name:

Case No:

CRISIS PLAN

Allergies (General):

--

Brief History:

--

Triggers:

--

Responsible Persons:

--

Current Diagnosis

Start Date of Diagnosis:

Diagnosis Priority:

DSM-5 Diagnosis:

ICD-10 Diagnosis:

Start Date of Diagnosis:

Diagnosis Priority:

DSM-5 Diagnosis:

ICD-10 Diagnosis:

Current Medications:

Family Vision

--

Team Mission

--
Plan Of Care

Youth Name: 

Case No: 

Printed: 

Needs, Outcomes, Strategies

Youth Needs 1

Describe the Need:

Start Date: 

End Date: --

Outcome Measure:

Barriers:

Desired Completion Date:

Life Domain:

Strategies:

Billable?

supports.

Review History (Maximum of 12):

<table>
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<tr>
<th>Date Reviewed</th>
<th>Progress Toward Need Met</th>
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</thead>
<tbody>
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<td>0 - Baseline</td>
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</tbody>
</table>

Progress Toward Need

Comments : 

Progress Toward Outcome Comments : 

Report Date : 

Power by Fidelity EHR

Disclaimer: This report contains confidential information and is protected under HIPAA Regulations. The contents should only be viewed by the intended recipient. If you are not the intended recipient, please destroy this report immediately. Violations of this policy will be prosecuted to the fullest extent of the law.
Youth Needs Progress

Youth Need Descriptions:
Need 1:

Rating Key:
4 - This need has been met to our satisfaction
3 - Good progress, with the need more than halfway met
2 - Some progress, with the need about halfway met
1 - A little progress, but the need is less than halfway met
0 - No progress has yet been made
Summary of Team Members:

<table>
<thead>
<tr>
<th>Start Date</th>
<th>Name</th>
<th>Role</th>
<th>Type</th>
<th>Phone 1 (Type)</th>
<th>Email</th>
</tr>
</thead>
</table>

Natural/Informal Supports

No records were found!

Family Voice and Choice:
My Family had voice and choice in the selection of services, providers and interventions, when possible, in the Wraparound process of building my family's Family Service Plan.

Parent/Guardian
Initials: __________________________

Youth Initials: ____________________

Report Date: ____________________
### Risk Assessment Matrix

Define the event in specific behavioral terms:

<table>
<thead>
<tr>
<th>Impact/Severity</th>
<th>Minimal</th>
<th>Marginal</th>
<th>Critical</th>
<th>Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likelihood Of Occurrence</td>
<td>Predictable</td>
<td>Probable</td>
<td>Possible</td>
<td>Remote</td>
</tr>
</tbody>
</table>

*ATTACHMENT FOUR*
Clermont County Wraparound Satisfaction Survey

Name: ___________________________          Date: ________

<table>
<thead>
<tr>
<th>Please Check the Box that Best Describes How You Feel about Your Experience with Clermont County Wraparound:</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Does Not Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Team meetings were a positive experience.</td>
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<tr>
<td>2. My team had a balance of professional and non-professional team members.</td>
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<td>3. My child was encouraged to participate in team meetings.</td>
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<td>4. My customs, beliefs and preferences were considered throughout meetings.</td>
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<td>5. I felt that my input and contribution to the team was respected and valued.</td>
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<td>6. The facilitator ensured that everyone’s input was obtained during team meetings.</td>
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<td>7. The facilitator kept the meetings on track and respected people’s time.</td>
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<tr>
<td>8. The team developed goals for my child that were based on our strengths and preferences.</td>
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<tr>
<td>9. The plans that were developed used the strengths (skills, talents, assets) of my family, child and other team members.</td>
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<tr>
<td>10. The safety of my child, family and community were discussed and plans were developed to address any needed safety concerns.</td>
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<tr>
<td>11. I believe a good plan was created to help support myself, my child and my family.</td>
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Please tell us in what areas the team, facilitator and/or program could improve:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

OFFICE USE ONLY
Level of Service Provided: ________ Information and Referral ________ Service Coordination

______ High Fidelity Wraparound
Wraparound Fidelity Index Short Form (WFI-EZ)
CAREGIVER FORM

This survey is for a caregiver of a youth in wraparound. We want to ask you about the experiences that you and your family have had as part of the Wraparound program, so we can make it better. You do not have to answer any questions that you don’t want to, and you may stop your participation at any time.

Thank you very much for your time.

Youth Information
Form completed on...

/ /

Youth/Family ID (The person who gave you this survey will give you this ID, or fill it in for you):

__________________________

Wraparound Site Location:

__________________________

Is your child of Hispanic descent?
☐ Yes ☐ No

What is the child’s race?
☐ African American ☐ Asian/Pacific Islander
☐ Caucasian ☐ Mixed Race
☐ Native-American/Alaska Native ☐ Other (please specify) ________________

Who has legal custody of the child?
☐ Two birth parents OR one birth parent and one step parent
☐ Birth mother only
☐ Birth father only
☐ Adoptive parent(s)
☐ Foster parent(s)
☐ Sibling(s)
☐ Aunt and/or uncle
☐ Grandparent(s)
☐ Friend(s)
☐ Ward of the state
☐ Other (please specify):

Section A: Basic Information

For the following questions, please respond either “Yes,” or “No.”

Yes No

A1: My family and I are part of a team (e.g., “wraparound team,” “child and family team”), AND this team includes more people than just my family and one professional. ☐ ☐

A2: Together with my team, my family created a written plan (“plan of care” or “wraparound plan”) that describes who will do what and how it will happen. ☐ ☐

A3: My team meets regularly (for example, at least every 30-45 days). ☐ ☐

A4: Our wraparound team’s decisions are based on input from me and my family ☐ ☐
### Section B: Your Experiences in Wraparound

For the following statements, please think about all of your experiences with wraparound. You will be asked whether you "Strongly Agree," "Agree," "Neutral," "Disagree," "Strongly Disagree," or "Don't Know."

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B1:</strong> My family and I had a major role in choosing the people on our wraparound team.</td>
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<td><strong>B2:</strong> There are people providing services to my child and family who are <strong>not</strong> involved in my wraparound team.</td>
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<td><strong>B3:</strong> At the beginning of the wraparound process, my family described our vision of a better future to our team.</td>
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<td><strong>B4:</strong> My wraparound team came up with creative ideas for our plan that were different from anything that had been tried before.</td>
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<td><strong>B5:</strong> With help from members of our wraparound team, my family and I chose a small number of the highest priority needs to focus on.</td>
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<td><strong>B6:</strong> Our wraparound plan includes strategies that address the needs of other family members, in addition to my child.</td>
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<td><strong>B7:</strong> I sometimes feel like our team does <strong>not</strong> include the right people to help my child and family.</td>
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<td><strong>B8:</strong> At every team meeting, my wraparound team reviews progress that has been made toward meeting our needs.</td>
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<td><strong>B9:</strong> Being involved in wraparound has increased the support my child and family get from friends and family.</td>
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<td><strong>B10:</strong> The wraparound process has helped my child and family build strong relationships with people we can count on.</td>
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<td><strong>B11:</strong> At each team meeting, our wraparound team celebrates at least one success or positive event.</td>
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<tr>
<td><strong>B12:</strong> Our wraparound team does <strong>not</strong> include any friends, neighbors, or extended family members.</td>
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<td><strong>B13:</strong> My family was linked to community resources I found valuable.</td>
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<tr>
<td><strong>B14:</strong> My wraparound team came up with ideas and strategies that were tied to things that my family likes to do.</td>
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<tr>
<td><strong>B15:</strong> Members of our wraparound team sometimes do not do the tasks they are assigned.</td>
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<tr>
<td><strong>B16:</strong> Our wraparound team includes people who are not paid to be there (e.g., friends, family, faith).</td>
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<tr>
<td><strong>B17:</strong> I sometimes feel like members of my wraparound team do not understand me and my family.</td>
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<td><strong>B18:</strong> Our wraparound plan includes strategies that do not involve professional services (things our family can do ourselves or with help from friends, family, and community).</td>
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<td><strong>B19:</strong> I am confident that our wraparound team can find services or strategies to keep my child in the community over the long term.</td>
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</tbody>
</table>
**Section B: Understanding Wraparound**

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>B20: Because of wraparound, when a crisis happens, my family and I know what to do.</td>
<td></td>
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<tr>
<td>B21: Our wraparound team has talked about how we will know it is time for me and my family to transition out of formal wraparound.</td>
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<td>B22: At each team meeting, my family and I give feedback on how well the wraparound process is working for us.</td>
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<td>B23: I worry that the wraparound process will end before our needs have been met.</td>
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<tr>
<td>B24: Participating in wraparound has given me confidence that I can manage future problems.</td>
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<td>B25: With help from our wraparound team, we have been able to get community support and services that meet our needs.</td>
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</table>

**Any additional comments about your family's experiences in wraparound, or about your wraparound experiences in general?**

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

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**Section C: Satisfaction**

For the following statements, please think about your satisfaction with wraparound. Indicate how much you agree with each statement.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Don't Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1: I am satisfied with the wraparound process in which my family and I have participated</td>
<td></td>
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<tr>
<td>C2: I am satisfied with my child or youth's progress since starting the wraparound process</td>
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<tr>
<td>C3: Since starting wraparound, our family has made progress toward meeting our needs</td>
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<td>C4: Since starting wraparound, I feel more confident about my ability to care for my child/youth at home</td>
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</table>

**Any additional comments about your satisfaction with wraparound?**

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
Section D: Outcomes

For the following questions, please respond either “Yes,” or “No.”

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>D1: Since starting wraparound, my child or youth has had a new placement in an institution (such as detention, psychiatric hospital, treatment center, or group home)</td>
<td></td>
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<tr>
<td>D2: Since starting wraparound, my child or youth has been treated in an Emergency Room due to a mental health problem</td>
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<tr>
<td>D3: Since starting wraparound, my child or youth has had a negative contact with police</td>
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<tr>
<td>D4: Since starting wraparound, my child or youth has been suspended or expelled from school</td>
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</table>

In the past month, my child or youth has experienced...

<table>
<thead>
<tr>
<th></th>
<th>Very much</th>
<th>A good deal</th>
<th>A little bit</th>
<th>Not at All</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>D5: Problems that cause stress or strain to me or a family member</td>
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<tr>
<td>D6: Problems that disrupt home life</td>
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<tr>
<td>D7: Problems that interfere with success at school</td>
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<td>D8: Problems that make it difficult to develop or maintain friendships</td>
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<tr>
<td>D9: Problems that make it difficult to participate in community activities</td>
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</tbody>
</table>

Any additional comments about your satisfaction with wraparound, or about what has happened to your child/youth since the start of wraparound?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Again, thank you very much for your time.
RELEASE OF INFORMATION

I, ________________________, hereby authorize the agencies and entities, which comprise the Clermont County Family and Children First wraparound team, service coordination team, HOME Choice team, and/or clinical review team and are initiated below, to exchange information (from whatever source derived) related to both my own participation and that of my minor child(ren) in the services they provide.

I understand that the identified agencies may be contacted (please initial).

<table>
<thead>
<tr>
<th>Child Focus, Inc.</th>
<th>Clermont County Juvenile Court</th>
<th>HOME Choice/Morning Sun Financial</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clermont County Children's Protective Services</td>
<td>Clermont Recovery Center**</td>
<td>Pressley Ridge</td>
</tr>
<tr>
<td>Clermont County Department of Job &amp; Family Services</td>
<td>Families Connected, Inc.</td>
<td>Other:</td>
</tr>
<tr>
<td>Clermont County Developmental Disabilities</td>
<td>Greater Cincinnati Behavioral Health Services</td>
<td>Other:</td>
</tr>
</tbody>
</table>

**A SEPARATE RELEASE OF INFORMATION MUST BE SIGNED BY THE PARENT/GUARDIAN WHEN COMMUNICATION/INFORMATION IS DESIRED FROM OR WITH CLERMONT RECOVERY CENTER.**

The purpose of the sharing of this information is to coordinate, plan and evaluate the services and supports provided by Clermont County Family & Children First.

I understand the following:

1. The purpose of this information sharing is to facilitate the referral for and coordination of treatment services and to evaluate the effectiveness of these services for my child(ren), family, and/or myself.

2. The above listed and initiated agencies and entities have agreed:
   a. To share this information only with others in accordance with this authorization.
   b. Not to share this information with non-affiliated agencies and entities without my written authorization unless otherwise required or authorized by law.

3. Any and all rights to confidentiality that I may have under state of federal law will continue, except for information covered by this form.

4. Any information related to the status HIV or AIDS confirmation will not be released without a written authorization to share the information specifying to whom and for what intended purpose.

5. I may revoke this Authorization at any time except related to information that has been previously exchanged.

6. This Release of Information shall not restrict the sharing of information otherwise authorized by law.

7. All reports and publications of findings related to the evaluation of services received will not reveal my name or that of my family members, and all information and results will be presented in group format.

8. This information is subject to re-disclosure.

Name of Parent/Guardian Parent/Guardian DOB Name of Parent / Guardian Parent/Guardian DOB

Name of the Child Date of Birth

Name of the Child Date of Birth

Name of the Child Date of Birth

Revised 11/18/16
Check one:

☐ This Release of Information covers the length of my involvement and the involvement of my child(ren) with Family and Children First, without expiration.

☐ I request that this Release of Information be reviewed and re-signed on ___________ (date) or in _______ months from the original date.

Subject to applicable state and federal law, I authorize the sharing of the following information regarding my child(ren) and me:

1. Records of services provided by any of the above-mentioned agencies or entities.
2. Psychological and medical testing, including but not limited to any IQ tests or other tests of cognitive or emotional functioning or mental status, and any reports of physical tests such as X-rays, CT scans, diagnostic blood testing, or other test results.
3. Medical records including, but not limited to, results of physical and mental examinations, diagnoses of physical and mental disorders, medication history, physical and mental health status and history, summary of treatment or services received, summary of treatment plans and treatment needs, social history and financial information.
4. Drug and alcohol abuse diagnoses and treatment including, but not limited to, results of evaluations, diagnoses, treatment and services received, treatment plans and treatment needs. (This information will be disclosed ONLY IF INITIALED here to permit such release _________________.) *
5. Any information regarding HIV and AIDS diagnoses and treatment. (This information will be disclosed ONLY IF INITIALED here to permit such release ________________). **

*Information disclosed pursuant to this authorization has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit further disclosure of alcohol or drug related diagnosis or treatment information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

**Information disclosed pursuant to 45 CFR 103 privacy rule. No information will be released regarding HIV/AIDS diagnosis and treatment without specific written consent to the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

AGREEMENT:

This Release of Information has been explained to me. I have been given a reasonable amount of time to ask questions and consider whether to permit sharing of this information. I hereby willingly agree to the sharing of information as described above.

Signature of Child ___________________________ Effective Date _____________

Signature of Parent/Guardian ___________________________ Effective Date _____________

Witness ___________________________ Effective Date _____________

☐ I revoke this release of information effective _____________ for ☐ all listed entities ☐ for entities listed below.

REFUSAL:

Initial and sign below:

_________________________ I refuse to allow my case information to be exchanged. I understand that my signing or refusing to sign this authorization will not affect public benefits or services to which I am otherwise entitled.

Signature of Child ___________________________ Effective Date _____________

Signature of Parent/ Guardian ___________________________ Effective Date _____________

Witness ___________________________ Effective Date _____________

Revised 11/18/16
WRAPAROUND TEAM SIGN IN

Listed below are the names/signatures of team members who participated in the development of the plan reflected above. Our signatures reflect our individual acknowledgement that we participated in the development of the plan. In addition, our signatures below reflect our commitment to follow through with the tasks and activities outlined in the plan.

<table>
<thead>
<tr>
<th>NAME</th>
<th>DATE</th>
<th>LOCATION</th>
<th>START TIME</th>
<th>END</th>
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</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Relationship/Agency</th>
<th>Phone #</th>
<th>Email Address</th>
<th>Mileage</th>
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</table>

** We the undersigned, agree to keep confidential all personal and identifying information and records regarding the child and family, whom the Wraparound Team Meeting is for, except otherwise provided for via separate and properly executed Releases of Information and in pending Juvenile Court or other Court action. A written summary of this meeting will be distributed to all participants.
**Policy Name:** Dispute Resolution Process  
**Policy Number:** 1.03.01  
**Effective Date:** 6/11/04  
**Revised:** 8/8/08, 9/11/09, 10/14/11, 2/13/15, 4/6/17, 11/1/18  

Karen Scherra  
Co-Chairperson  

Judy Eschmann  
Co-Chairperson  

Date  
**Date:** 11/19/18  

Clermont County Family and Children First Council
Cross Reference
N/A

Policy Statement

It is the policy of the Clermont County Family and Children First Council (Council) to resolve any dispute within and regarding the Council, a Family and Children First (FCF) representative or a FCF funded program in a timely manner.

Purpose

To define the process of dispute resolution to be followed by the Council when agreement cannot be reached or concerns arise.

Key Terms

*Complainant – the person(s) who is in disagreement with a decision or has a concern regarding the Council, an FCF representative or an FCF funded program and follows the dispute resolution process.*

*Dispute Resolution Committee (DRC): The DRC reviews all complaints received by FCF and works to develop a plan consistent with the child’s needs and meeting the concerns of each system responsible for providing services and/or funding. DRC members are the FCF Program Administrator, Chair or Co-Chairs of FCF Council, a parent representative, and at least one other FCF Council members as voted on by FCF Council. DRC membership continues until a member requests to be removed from the DRC.*

Procedure

I. The complainant will state his/her disagreement or concern either verbally or in writing to the FCF Program Administrator.

A. Parents and children (when age appropriate) must have access to the dispute resolution process.

B. All agencies involved with FCF or the family must have access to the dispute resolution process.

C. All Council members and FCF staff must have access to the dispute resolution process.

D. Families involved with Clermont County Early Intervention Service Coordination may utilize Policy 1.03.02 – Dispute Resolution Process (Early Intervention Service Coordination)
II. For routine (non-emergent) situations:

A. The FCF Program Administrator will gather all relevant information from the complainant and other involved individuals/agencies. This includes recommendations proposed and alternatives developed or considered by the Wraparound team and/or providers and agencies.

B. The FCF Program Administrator will schedule a meeting or conference call with the Council’s Dispute Resolution Committee (DRC) within ten (10) business days of receipt of the information regarding the disagreement or concern.

C. The DRC shall make a good faith effort to develop a plan consistent with the child’s needs and meeting the concerns of each system responsible for providing services and/or funding.

D. The DRC shall attempt to develop a consensus, but shall proceed by majority vote as may be necessary to formulate a recommended resolution.

E. The FCF Program Administrator will communicate the recommended resolution of the DRC to the complainant in writing within five (5) business days of the decision.

III. For emergent situations:

A. The FCF Program Administrator will gather all relevant information from the complainant and other involved individuals/agencies. This includes recommendations proposed and alternatives developed or considered by the Wraparound team and/or providers and agencies.

B. The FCF Program Administrator will schedule a meeting or conference call with the Council’s DRC within one (1) business day of receipt of the information regarding the disagreement or concern.

C. The DRC shall make a good faith effort to develop a plan consistent with the child’s needs and meeting the concerns of each system responsible for providing services and/or funding.

D. The DRC shall attempt to develop a consensus, but shall proceed by majority vote as may be necessary to formulate a recommended resolution.

E. The FCF Program Administrator will communicate the recommended resolution of the DRC to the complainant verbally within two (2) hours of
IV. The child and/or family will receive necessary services while the dispute is being resolved.

V. All parties shall make a good faith effort to work with the recommended resolution to the extent that it is not contradictory to legal responsibilities and fiscal capabilities.

VI. All DRC decisions are final with the exception being those disputes specified in ORC 121.38 – Resolving agency disputes concerning services or funding. In this situation, the steps outlines in ORC 121.38 shall be followed.

VII. The FCF Program Administrator shall record all disputes/concerns on a Dispute Resolution Form (see attached).

VIII. The completed Dispute Resolution Form and the written recommended resolution of the dispute/concern will be maintained in the FCF Program Administrator’s office.

IX. The FCF Council’s DRC will review all disputes/concerns at least annually to determine trends and/or service areas for improvement.

X. If a complaint or concern is regarding the FCF Program Administrator or an agency sitting on the committee, a substitute member will be asked to sit on the committee in that person’s place.

XI. All FCF agencies shall have their own complaint/concern policy or procedure. The FCF Dispute Resolution Committee will be used secondary to that agency’s policy or procedure and concerning FCF functions and decisions.

XII. The complainant may choose to ask Clermont County FCF to make a referral to Ohio Family & Children First (OFCF) for an administrative review of a service coordination complaint. The required process for an administrative review by OFCF is attached.

Associated Forms & Attachments

Clermont County FCF Dispute Resolution Form
OFCF Dispute Resolution Review Process
OFCF Service Coordination Dispute Referral form
OFCF Administrative Review – Dispute Resolution Referral Checklist
OFCF County FCFC Authorization to Request an Administrative Review
DISPUTE RESOLUTION FORM

Name of Complainant: ______________________ Date: _______ Time: _______

Complainant is a:

☐ Parent  ☐ Child  ☐ Guardian
☐ Agency representative  ☐ FCF Council member  ☐ FCF staff

Dispute/Concern is:

☐ Routine  ☐ Emergent

Nature of dispute/concern:

________________________________________________________________________

Received by ______________________ Date _______ Time _______

FCF Program Director

Meeting/conference call with Dispute Resolution Committee:

_________________________________________ ______________________
Date Time
Dispute Resolution Committee members participating:


Decision of Dispute Resolution Committee


Communicated to Complainant:

☐ Verbally (if emergent only)

Date

Time

☐ In writing

Date

Time

Attach written response to dispute/concern to this form. Form to be maintained in dispute/concern file in FCF Program Director’s office.
Ohio Family and Children First
Service Coordination Committee

Dispute Resolution Review Process

OFCF Staff and SC Committee’s Roles and Responsibilities
1. OFCF Staff will make sure that the dispute packet is complete, including release of
information signed by parent and authorization and verification form signed by
appropriate council members.

2. OFCF Staff will request missing documents or information from county council.

3. Committee will identify a Service Coordination Committee member as point lead for the
review.

4. Service Coordination Committee will review dispute referral packet.

The review process will include:
   a) Review the Family Service Coordination Plan.

   b) Identify the parties involved in the dispute.

   c) Review the issues that are causing the dispute.

   d) Review the child’s and parents’/legal custodian’s position regarding the dispute.

   e) Review each party’s position regarding the dispute, including the county council.

   f) Review the interventions being provided.

   g) Consider whether services and supports are being provided in the least restrictive
environment possible.

   h) Consider whether natural supports and creative options are being utilized.

   i) Consider the preferences of the parents’/legal custodian’s and child.

   j) Consider other services/supports that could be implemented to resolve the dispute.

   k) Consider process difficulties/concerns that may be preventing the family’s needs from
being met?

   l) Identify other existing funding sources that may not have been considered by county.

Service Coordination Committee members present will review findings and make
recommendations. Recommendations will be forwarded to the OFCF Cabinet Council.

Revised February 17, 2009
# Service Coordination Dispute Referral

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>DOB</th>
<th>Sex</th>
<th>Race/Ethnicity</th>
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<thead>
<tr>
<th>County of Residence</th>
<th>Current Living Arrangement</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Parent(s), Guardian, Legal Custodian</th>
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<table>
<thead>
<tr>
<th>Street Address</th>
<th>City and Zip</th>
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<table>
<thead>
<tr>
<th>FCF Council Coordinator/Director Name</th>
<th>Phone Number and Email</th>
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<th>Service Coordinator Name</th>
<th>Affiliation</th>
<th>Phone Number and Email</th>
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<tr>
<th>FCF Council Chair</th>
<th>Agency/Family Representative</th>
<th>Phone Number and Email</th>
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<tr>
<th>Eligibility</th>
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</table>

- Healthy Start
- TANF
- IV-E
- SSI
- SSDI
- PASS

- Insurance
- BCMH
- Help Me Grow
- IV-B (Ed)

- Other

## Identifying Residents of child’s home by Name

<table>
<thead>
<tr>
<th>No.</th>
<th>Relationship to child</th>
<th>Gender of individual</th>
<th>Age of individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>(legal custodian)</td>
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<tr>
<td>2.</td>
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<td>9.</td>
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<tr>
<td>10.</td>
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</tbody>
</table>

Please check yes or no for each question and attach requested documentation.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there an FCF Council Family Service Coordination Plan for this family? (If yes, please attach plan.)</td>
<td></td>
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<tr>
<td>Has family been a participant in the development and on-going implementation of its Family Service Coordination Plan?</td>
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<tr>
<td>Has a family strengths, needs and cultural discovery assessment been completed? (If yes, please attach results showing family strengths and needs.)</td>
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<td></td>
</tr>
<tr>
<td>Crisis/safety plan developed? (If, yes please attach plan.)</td>
<td></td>
<td></td>
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<tr>
<td>Family advocate? (Has advocate been requested and is a participating member of the family team?)</td>
<td></td>
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</tbody>
</table>
Describe (in detail) the unresolved dispute, including the position and the rationale for the position of each party with an opposing position. Opposing parties in the dispute may attach their own statements of their positions to this document. Please attach a statement from the parents/legal guardian that explains their position and feelings about the dispute. (Space will expand to accommodate response.)

Describe the position of the council regarding this case as determined through the council dispute resolution process.
☐ Complete the Dispute Resolution Review Referral Form.

☐ Attach the individual Family Service Coordination Plan developed by the family team.

☐ Attach the results of the strengths, needs and cultural discovery assessment that was completed for this family.

☐ Attach the crisis/safety plan for this family.

☐ Attach rules of probation or parole, if applicable.

☐ Attach a release of information signed by this family to share personal information with the OFCF State Service Coordination Committee and Cabinet Council.

☐ Attach a written statement from the parents/legal guardian that explains their positions and feelings about the dispute.

☐ Attach the signed council authorization to request the administrative dispute review.

☐ Mail or email referral packet to your OFCF Regional Coordinator.

Scanned signed documents may be emailed for electronic submission. If you have a question regarding this process, please contact your regional coordinator. If you do not know who your regional coordinator is, please refer to the regional map included in this packet. You will receive a response from the Committee within 30 days of the Committee’s receipt of your request.

**East Central Region**
Janice Houchins
OSU Extension
1680 Madison Ave.
Wooster, OH 44691
330-263-3632 (office)
330-466-0577 (cell)
330-263-3667 (fax)
jhouchins@ag.osu.edu

**South Central Region**
Joyce Calland
OSU Extension
1512 South US Hwy 68
Urbana, OH 43078
(937)484-1526 (office)
(937) 232-4255 (cell)
(937)484-1540 (fax)
jcalland@postoffice.ag.ohio-state.edu

**North Central Region**
Teresa Reed-McGlashan
OSU Extension
240 W. Lake St., Unit C
Oak Harbor, OH 43449
(419)579-4397 (cell)
(419) 898-3631 (ph)
(419) 898-3232 (fax)
trmcglash@postoffice.ag.ohio-state.edu
County FCFC Authorization to Request an Administrative Review

County FCFC: _______________________________  Child/Family Name: _______________________________

Council Coordinator/Director: _______________________________

Phone: _______________________________  Email: _______________________________

Family SC Team Facilitator (if different than above):

Phone: _______________________________  Email: _______________________________

The County Family and Children First Council is requesting the following Administrative Review: (Please Check One)

☐ Individual Family Plan Administrative Review

☐ Dispute Resolution Administrative Review

The FCFC Chair and FCFC Coordinator/Director have signed below authorizing this request for an Administrative Review of the type checked above on behalf of the County Family and Children First Council. In authorizing this request, we verify that the type of review being requested meets the requirements outlined in the Ohio Family and Children First’s Administrative Review Guidelines.

________________________________________________________________________
FCFC Chair _______________________________  Date _______________________________

________________________________________________________________________
FCFC Coordinator/Director _______________________________  Date _______________________________

In addition, the parent/s or legal guardian/s of the involved child/youth and the youth give their approval of this request and give permission to have personal family information contained in the family service coordination plan shared with the Ohio Family and Children First State Service Coordination Committee and Cabinet Council.

________________________________________________________________________
Parent/Legal Guardian _______________________________  Date _______________________________

________________________________________________________________________
Parent/Legal Guardian _______________________________  Date _______________________________

________________________________________________________________________
Child/Youth’s Signature _______________________________  Date _______________________________

Submit referral packet along with this authorization and the Family Release of Information to the county’s OFCF Regional Coordinator.

Revised February 17, 2009