WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

West Virginia Wraparound
Individual Plan of Care (POC)

A.1 Referral Information

Date of Referral:	Source/County:	Referral Person & Contact Information:
Date of Eligibility:	Anchor Date:	Date of Current POC & POC type:

A.2 Enrolled Program Under WV Wraparound

☐ Interim Wraparound Services ☐ BBH ☐ BSS	☐ Safe at Home (BBS)
☐ CSED Waiver (BMS) Provider (WF) Agency Name	☐ Children's Mental Health Wraparound (BBH)

B.1 Identified Youth Demographic Information

Youth Name:		Diagnoses: ICD-10 codes only
Date of Birth:	Preferred Name:	
Telephone:	Plan ID:	Secondary Insurance:

Current Address:
Guardian Address: ☐ Check if the Same as Member Current Address

B.2 Current Living Situation

☐ Family	☐ Guardian/Kinship	☐ Residential Treatment Facility	☐ Out of State Placement	☐ Foster Care Placement
☐ Homeless	☐ Emergency Transitional Shelter	☐ Independent Living on Own	☐ Other:	

B.3 Academic Information

Academic Setting:	School Name:	
IEP/504: ☐ Yes ☐ No	GPA:	Grade Level:
Date of Recent IEP/504:	Other/Misc.:	

C.1 Family Information

Name/Relationship	Involvement Status (fully active, semi-active, other)	Contact Information

C.2 Other Potential Team Supports: *This section should be used to describe additional supports for the youth/family that will assist in reaching their goals.*

Name (Relationship or Position)	What is their current role in the support system?	Who Contacts/Engages?

C.3 Team Strengths: *This includes all team members and should be updated as needed.*

Team Member	Strengths	Team Member	Strengths

C.4 Ground Rules: *Identify the Ground Rules & Team Process, including how decisions are made. It is important to create a safe, respectful environment where all ideas can be heard. This section should be used to set ground rules for the meeting and describe how the youth/family will participate in their care*.

C.5 Family Vision: *This is determined by the identified youth and their family, with the facilitator's help, prior to the first team meeting. The rating scale if decided by the family to look at progress and outcomes.*

Vision Description:
Rating Scale:
Progress towards family vision:

C.6 Team Mission: *This is determined by the team in the first team meeting. The rating scale is determined by the team to look at progress and outcomes.*

Mission Description:
Rating Scale:
Progress towards team mission:

D. Putting it All Together: *These 2-3 needs (one for youth, one for family/caregiver) are decided upon by the team from the 4 – 6 needs the identified youth and family and facilitator bring to the first meeting.*

Need 1: *relate to how the reason for the referral impacts them*	
Rating Scale:	**Rating of Need Being Met:**

Outcome Statement(s) and Baseline(s): *Relate back to reason for referral*	**Progress Towards Outcome Statement:**

Life Domain Area of Need:

☐ Physical Health ☐ Social Health ☐ Behavioral Health ☐ Transition to Adulthood

Timeline: *include start date and targeted completion date/duration*

Strengths-Based Strategies	**Tasks**: *include who is responsible for completing the task*	**Frequency**	**Duration**	**Start Date and Projected End Date**	**Progress**

Need 2: *relate to how the reason for the referral impacts them*

Rating Scale:	**Rating of Need Being Met:**
Outcome Statement(s) and Baseline(s): *Relate back to reason for referral*	**Progress Towards Outcome Statement:**

Life Domain Area of Need:

☐ Physical Health ☐ Social Health ☐ Behavioral Health ☐ Transition to Adulthood

Timeline: *include start date and targeted completion date/duration*

Strengths-Based Strategies	**Tasks**: *include who is responsible for completing the task*	**Frequency**	**Duration**	**Start Date and Projected End Date**	**Progress**

Need 3: *relate to how the reason for the referral impacts them*					
Rating Scale:			**Rating of Need Being Met:**		
Outcome Statement(s) and Baseline(s): *Relate back to reason for referral*			**Progress Towards Outcome Statement:**		

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Life Domain Area of Need:

☐ Physical Health ☐ Social Health ☐ Behavioral Health ☐ Transition to Adulthood

Timeline: *include start date and targeted completion date/duration*

Strengths-Based Strategies	**Tasks**: *include who is responsible for completing the task*	**Frequency**	**Duration**	**Start Date and Projected End Date**	**Progress**

E. Wraparound Crisis/Safety Plan: *This is the completed/expanded version from the initial crisis/safety plan created by the facilitator and family in the first face to face meeting. This is to be reviewed and updated as needed, and at least at every meeting.*

Current Medications:	Brief History:
Triggers:	Potential Crisis:
Action Steps for All Areas (including proactive steps):	Back Up Plan:
Follow Up Tasks After Crisis:	
Person's Responsible and Phone Numbers:	

F. Transition to Adulthood Plan: *For identified youth aged 14 and up, this section is used to discuss goals as they start to transition into adulthood, also available service connections and community supports.*

G. Monthly Celebration of Successes and Accomplishments

H. Discharge Plan

Support Summary: how will the identified youth and family continue after wraparound?
Further Recommendations: what else will be helpful for the identified youth and family after wraparound?

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Contact List

Name	Role	Contact Information

Signatures

Name & Relationship	Phone Number	Date	Signature	Do you agree with the POC Update?	Date POC Sent:

J. Assessments

CHILD & ADOLESCENT NEEDS AND STRENGTHS (CANS)

Date Completed and Person Completing:	**Date Completed and Person Completing:**
Strength rates at 0 or 1:	**Strengths rates at 0 or 1:**
Needs rates at 2:	**Needs rated at 2:**
Needs rated at 3:	**Needs rated at 3:**

Date Completed and Person Completing:	**Date Completed and Person Completing:**
Strength rates at 0 or 1:	**Strength rates at 0 or 1:**
Needs rates at 2:	**Needs rates at 2:**
Needs rated at 3:	**Needs rated at 3:**

CAFAS/PECFAS

Date Completed:	**Person Completing:**	**Total Score:**
Date Completed:	**Person Completing:**	**Total Score:**

BEHAVIOR ASSESSMENT SYSTEM FOR CHILDREN, 3RD EDITION (BASC-3)

Initial Date Completed:	
Form Completed/Respondent:	**Items Rated "At Risk" (by general or clinical population):**
	Items Rated "Clinically Significant" (by general or clinical population):
Additional Form Completed/Respondent:	**Items Rated "At Risk" (by general or clinical population):**
	Items Rated "Clinically Significant" (by general or clinical population):

ADDITIONAL IMPORTANT ASSESSMENTS

CSED Waiver Services Needed to Support ME: POC

Service Code	**Service Description**	**Provider:** *include name of staff person*	**Is this service available/accessible**
			☐ Yes ☐ No
HCBS CSED Agency:			
Amount/Frequency: *Average units per month & limit*			
Duration of Service: *beginning and end dates*			
How does this service support the POC and member goals?			

Service Code	**Service Description**	**Provider:** *include name of staff person*	**Is this service available/accessible**
			☐ Yes ☐ No
HCBS CSED Agency:			
Amount/Frequency: *Average units per month & limit*			
Duration of Service: *beginning and end dates*			
How does this service support the POC and member goals?			