

# West Virginia Wraparound Individual Plan of Care (POC)

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A.i Referral information		To 10 1		156 15 00 1116 11	
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 Sei	rvices				
			Safe at Home (	BBS)	
BBH BSS					
CSED Waiver (BMS)					
			Children's Mental Health Wraparound (BBH)		
Provider (WF) Agency Name					
B.1 Identified Youth Demogra	aphic Information				
Youth Name:				Diagnoses: ICD-10 codes only	
Date of Birth:		Preferred Name:			
Telephone:	!	Plan ID:		Secondary Insurance:	



Member Current Address				
n				
Guardian/Kinship			Out of State Placement	Foster Care Placement
Emergency Transitional Shelter	Independent Living on Own		Other:	
		1		
	So	chool Name:		
GPA:			Grade Level:	
I	0	ther/Misc.:		
	n Guardian/Kinship Emergency Transitional Shelter	Guardian/Kinship  Emergency Transitional Shelter  GPA:  Residenti Treatment Independ Living on	Guardian/Kinship Residential Treatment Facility  Emergency Transitional Shelter Independent Living on Own  School Name:	Guardian/Kinship  Residential Treatment Facility  Dut of State Placement  Independent Living on Own  Other:  School Name:  GPA:  GPA:  Grade Level:



**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.

Strengths	Team Member	Strengths	
	Strengths	Strengths Team Member	Strengths Team Member Strengths





	the Ground Rules & Team Process, including how decisions are made. It is important to create a safe, re all ideas can be heard. This section should be used to set ground rules for the meeting and describe how the n their care
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	letermined 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 Vision Description:	e family to look at progress and outcomes.
Vision Description.	
Rating Scale:	
rtaining Coulo.	
Progress towards family vision	
Frogress towards fairling vision	1.



**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.

and batcomes.	
Mission Description:	
Rating Scale:	
Progress towards team mission:	
D. Putting it All Together: These 2-3 needs (one for youth, one for fall	mily/caregiver) are decided upon by the team from the $4-6$ needs
the identified youth and family and facilitator bring to the first meeting.	mily caregivery are decided apoin by the team from the 4 of needs
Need 1: relate to how the reason for the referral impacts them	
Need 1. relate to now the reason for the retental impacts them	
Rating Scale:	Rating of Need Being Met:



Outcome Statement(s) and Baseline(s): Relate back to reason for		Progress Towards Outcome Statement:			
<u>referral</u>					
Life Domain Area of Need	•				
Physical Health	Social F	lealth	Behavioral	Health	Transition to Adulthood
Timeline: include start date	and targeted completion date	e/duration			
Strengths-Based Strategies	Tasks: include who is responsible for completing the task	<u>Frequency</u>	<u>Duration</u>	Start Date and Projected End Date	<u>Progress</u>



N. 10 III II					
Need 2: relate to how the re	eason for the referral impacts t	<u>them</u>			
Rating Scale:			Rating of Need	Being Met:	
Outcome Statement(s) and referral	d Baseline(s): Relate back to	reason for	Progress Towar	ds Outcome State	ment:
<u>rererrar</u>					
Life Domain Area of Need					
Di : 111 W	0 : 11		5		- ''' A A I III I
Physical Health	Social F	leaith	Behavioral	Health	Transition to Adulthood
Timeline: include start date	and targeted completion date	e/duration			
	<u>, , , , , , , , , , , , , , , , , , , </u>				
	Tasks: include who is			Start Date and	
Strengths-Based Strategies	responsible for completing	Frequency	<b>Duration</b>	Projected End	Progress

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			CI	
3		V I		-3

• JERTIGES					
Need 2: valate to be with a va	and for the referred improved	6 la a 100			
<b>Need 3</b> : relate to now the re	ason for the referral impacts t	<u>nem</u>			
Pating Scale:			Rating of Need B	oina Mot:	
Rating Scale:			Nauliy of Need D	enig wet.	
Outcome Statement(s) and Baseline(s): Relate back to reason for			Progress Towards Outcome Statement:		
Cattonie Gtatement(3) and	a Basennets). Notate back to	TCason IOI	i logicas lowalu	5 Julionie Glaten	iont.
<u>referral</u>					



Life Domain Area of Need:					
Physical I	Health S	Social Health	Behav	ioral 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	<u>Duration</u>	Start Date and Projected End Date	<u>Progress</u>



**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.

Tarring in the first race to race meeting. This is to be reviewed and upod	
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:	



	ood Plan: For identified you e service connections and			o discuss goals as they	start to transition into
Juli 1000, also avallab	s service connections and	community supports	).		
Mandala Oalah nadia	£0 A	!! - !			
Monthly Celebratio	n of Successes and Acco	mpiisnments			
Discharge Blan					
Discharge Plan	will the identified youth and f	family continue after w	ranaround?		
apport Carimiary: Hov	win the identified youth and i	diffing continue diter w	raparouna:		
urther Becommendat	ons: what else will be helpful	for the identified youth	and family after wrongs	cound?	
urther Recommendat	Milat else Will be helpful	lor the identified yout	i anu iamily alter wrapar	ound?	



#### **Contact List**

Name	Role	Contact Information



### **Signatures**

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



#### 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:		
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 O	CHILDREN, 3RD EDITION (BASC-3)				
Initial Date Completed:					
Form Completed/Respondent:	Items Rated "At Risk" (by general or clinical po	opulation):			
	Itoms Pated "Clinically Significant" /by gonera	Lor clinical population):			
	Items Rated "Clinically Significant" (by general or clinical population):				
Additional Form Completed/Respondent:	Items Rated "At Risk" (by general or clinical po	opulation):			
	Items Rated "Clinically Significant" (by genera	l or clinical population):			
ADDITIONAL IMPORTANT ACCESSMENTS					
ADDITIONAL IMPORTANT ASSESSMENTS					



## **CSED Waiver Services Needed to Support ME**: POC

Service Code	Service Description	Provider: include name of staff	<u>Is this service</u>
		<u>person</u>	available/accessible
			Yes
			No
HCBS CSED Agency:			
Amount/Frequency: Aver	rage units per month & limit		
Dunation of Complex has	anima and and datas		
Duration of Service: begi	nning and end dates		
Have done this commiss of	most the DOC and momber week?		
now does this service st	upport 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	oer month & limit							
Duration of Service: beginning and	end dates							
How does this service support the POC and member goals?								



Amount/Frequency: Average units per month & limit

How does this service support the POC and member goals?

**Duration of Service**: beginning and end dates

Service Code	Service Description	Provider: include name of staff	Is this service
		<u>person</u>	available/accessible
			Yes
			No
HCBS CSED Agency:		,	
Amount/Frequency: Average units	per month & limit		
<b>Duration of Service</b> : beginning and	end dates		
How does this service support the	POC and member goals?		
	•		
Service Code	Service Description	Provider: include name of staff	Is this service
		person	available/accessible
			Yes
			No
HCBS CSED Agency:	1	'	

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**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	Is this service
		<u>person</u>	available/accessible
			Yes
			No
HCBS CSED Agency:			
Amount/Frequency: Average units p	<u>oer month &amp; limit</u>		
Duration of Service: beginning and	<u>end dates</u>		
How does this service support the	POC and member goals?		
Service Code	Service Description	Provider: include name of staff	Is this service
		<u>person</u>	available/accessible
			Yes
			No
HCDC CCED Agency:			INO
HCBS CSED Agency:			



**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	Is this service		
		<u>person</u>	available/accessible		
			Yes		
			No		
HCBS CSED Agency:	-				
Amount/Frequency: Average units per month & limit					
Duration of Service: beginning and	<u>end dates</u>				
How does this service support the	POC and member goals?				
	10		T		
Service Code	Service Description	Provider: include name of staff	Is this service		
		<u>person</u>	available/accessible		
			Yes		
			No		
LIODO COED Amenous	<u>l</u>		110		
HCBS CSED Agency:					
A					
Amount/Frequency: Average units	<u>per montn &amp; iimit</u>				



Service Code	Service Description	Provider: include name of staff	<u>Is this service</u>		
		<u>person</u>	available/accessible		
			Yes		
			No		
HCBS CSED Agency:					
Amount/Frequency: Average units per month & limit					
- meaning requester to the partition of mine					
Duration of Service: beginning and end dates					
= <u>g</u>					
How does this service support the	POC and member goals?				
The state of the support and					
Service Code	Service Description	Provider: include name of staff	Is this service		
Service Code	Service Description	Provider: include name of staff	Is this service		
Service Code	Service Description	Provider: include name of staff person	available/accessible		
Service Code	Service Description				
Service Code	Service Description		Yes		
	Service Description		available/accessible		
Service Code  HCBS CSED Agency:	Service Description		Yes		
	Service Description		Yes		
HCBS CSED Agency:			Yes		
			Yes		
HCBS CSED Agency:			Yes		
HCBS CSED Agency:  Amount/Frequency: Average units	per month & limit		Yes		
HCBS CSED Agency:	per month & limit		Yes		
HCBS CSED Agency:  Amount/Frequency: Average units	per month & limit		Yes		
HCBS CSED Agency:  Amount/Frequency: Average units	per month & limit end dates		Yes		