WV 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 (BSS)
☐ CSED Waiver (BMS)	☐Children's Mental Health Wraparound (BBH)

B.1 Identified Youth Demographic Information

Youth Name:		Preferred Name:
Date of Birth:	Diagnoses: *ICD-10 codes only*	Plan ID or Medicaid ID:
Telephone:		Secondary Insurance:☐
Current Address:		
Guardian Address: ☐If same as 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 or ☐ 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 is decided by the family to look at progress and outcomes.*

Rating Scale: **Progress towards family vision:**

C.6 TEAM MISSION: *This is determined by the team as a whole in the first team meeting. The rating scale is determined by the team to look at progress and outcomes.*

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 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)					
STRENGTH-BASED STRATEGIES	**TASKS (include who is responsible for completing the task)**	**FREQUENCY**	**DURATION**	**START DAT E AND PROJECTED END DATE**	**PROGRESS**

Need 1 Continued:

STRENGTH-BASED STRATEGIES	TASKS (include who is responsible for completing the task)	FREQUENCY	DURATION	START DAT E AND PROJECTED END DATE	PROGRESS

Need 2: relate to how the reason for 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)					
STRENGTH-BASED STRATEGIES	**TASKS (include who is responsible for completing the task)**	**FREQUENCY**	**DURATION**	**START DAT E AND PROJECTED END DATE**	**PROGRESS**

Need 2 Continued:

STRENGTH-BASED STRATEGIES	TASKS (include who is responsible for completing the task)	FREQUENCY	DURATION	START DAT E AND PROJECTED END DATE	PROGRESS

Need 3: relate to how the reason for 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)					
STRENGTH-BASED STRATEGIES	**TASKS (include who is responsible for completing the task)**	**FREQUENCY**	**DURATION**	**START DAT E AND PROJECTED END DATE**	**PROGRESS**

Need 3 Continued:

STRENGTH-BASED STRATEGIES	TASKS (include who is responsible for completing the task)	FREQUENCY	DURATION	START DAT E 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:**
Actions Steps for All Areas (including proactive steps):	**Back Up Plan:**
Follow Up Tasks after Crisis:	
Person's Responsible and phone numbers: Children's Mobile Crisis Response: 1-844-435-7498	

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?)*

I. Contact List

Name	Role	Contact Information

SIGNATURES

Name & Relationship	Phone Number	Date	Signature	Do you agree with the POC update?	Date POC Sent:
				☐ Yes or ☐ No	
				☐ Yes or ☐ No	
				☐ Yes or ☐ No	
				☐ Yes or ☐ No	
				☐ Yes or ☐ No	
				☐ Yes or ☐ No	
				☐ Yes or ☐ No	
				☐ Yes or ☐ No	
				☐ Yes or ☐ No	

J. ASSESSMENTS

CHILD & ADOLESCENT NEEDS AND STRENGTHS (CANS)

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

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

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

Date Completed and Person Completing:
Strengths rated at 0 or 1::
Needs rated at 2:
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 Rate "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 Plan of Care			
Service Code	**Service Description**	**Provider (include Name of staff person)**	**Is this service available/ accessible**
			☐ **Yes** ☐ **No**
HCBS CSED Agency:			
Amount/Frequency: Service should average units per month & should not exceed ____ units per year.			
Duration of Service: This service should begin on and end on			
How does this service support the POC and members goals?			

CSED Waiver Services Needed to Support ME Plan of Care			
Service Code	**Service Description**	**Provider (include Name of staff person)**	**Is this service available/ accessible**
			☐ **Yes** ☐ **No**
HCBS CSED Agency:			
Amount/Frequency: Service should average units per month & should not exceed ____ units per year.			
Duration of Service: This service should begin on and end on			
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How does this service support the POC and members goals?			