**Admission Criteria:**

* Currently residing in Pinellas or Pasco County
* Youth between 10 and 16 years of age
* Previous diagnosis within DSM-V OR Exhibiting behaviors that meet diagnosis, (Excluding principal diagnoses of organic brain syndrome or a V-Code)
* Receiving (or need of) services from two or more systems such as Drug and Alcohol, Education, Vocational Rehabilitation, Criminal/Juvenile Justice, Child Welfare, Foster Care, Economic Self-Sufficiency, etc.
* Youth’s identified barrier to wellness must have been present for at least a year or is expected to persist for a year or more based on diagnosis or multi-agency involvement
* Lack of intensive case management services would result in juvenile/adult court involvement or out-of-home placement including crisis stabilization unit, inpatient unit, state mental hospital or foster home.

**Program Goals:**

* Increase youth’s ability to advocate for their needs through access to choose services;
* Increase youth’s ability to share their lived experience and story through program evaluation and other leadership opportunities.
* Reduce the stigma surrounding mental health services;
* Decrease unexcused absences from school; Increase in positive self-reports of well-being at work/school;
* Increase in positive supports; Increased personal wellness through effective use of medical care;
* Decreased use of drugs and/or alcohol use;
* Develop a concrete network of support made up of community members, family members, and friends.
* Decrease incidents of Baker Acts, Crisis Stabilization Services, and arrests.
* Increase the youth successful High School Graduation/GED Attainment

**Intervention Model:**

* WRAPAROUND Processes through the development of a Family support plan that gives volume to the youth’s voice and their vision for their future. Enhancing communication between the youth and their family, service providers, and support system members.
* Care Coordination: Assessing, Advocating, Linkage, and Monitoring of service progress.
* Mentoring, Peer Support and coaching.
* Participate in the National Outcome Measurements through the use of consumer surveys and assessments to insure the individual’s voice and choice is directing the services they receive.

**How to make a referral to Wraparound:**

* Complete Referral Form and Email to Courtney Hendrickson at [chendrickson@directionsforliving.org](mailto:chendrickson@directionsforliving.org)
* Please reach out to Jo Dee Nicosia 813.539.0095 or e-mail [JNicosia@CFBHN.org](mailto:JNicosia@CFBHN.org) for questions or concerns

**FCMHSOC Referral Form**

**Date of Intake: \_\_\_\_\_\_\_**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Referral Source:**  **Name/ e-mail/#** | | **Date Received** | | | | | **Reason for referral**  (check box) The family has been informed a referral has been made and agrees to be contacted. | | | | | |
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| **Demographic Information**  Residing in Pasco Or Pinellas County Youth aged 10 – 16 | | | | | | | | | | | | |
| Youth Name:  Address: | | | | | | | | Current Insurance (*Check One):*  Medicaid  Kid Care  Private None  Living with Parent/Guardian? Yes No  Guardian Name: | | | | |
| Best Phone #/time: | | | | Work Phone #: | | | | | | School/Grade: | | |
| Primary Language: | | | | DOB/ Age:  Youth aged 10 – 16 | | | | | | Race: | | |
| E-mail: | | | | | | | | | | | | |
| **Diagnosis and Medication**  Diagnosis within DSM-V or suspect a diagnosis OR thoughts/behaviors related to self-harm/harm to others. | | | | | | | | | | | | |
| DSM V Diagnosis: | Yes | | No | | | Unknown | | | On medication currently? | | Yes | No |
| Diagnosis/ Suspected Diagnosis: | | | | | | | | | | | | |
| **Other systems or providers connected to the family**  Receiving or need of services from two or more human service agencies or public systems such as Drug & Alcohol, Education, Vocational Rehabilitation, Criminal/Juvenile Justice, Child Welfare, etc.… | | | | | | | | | | | | |
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\*Please reach out to Jo Dee Nicosia 813.539.0095 or e-mail [JNicosia@CFBHN.org](mailto:JNicosia@CFBHN.org) for questions or concerns\*\*

**E-mail completed referral to:**

[**chendrickson@directionsforliving.org**](mailto:chendrickson@directionsforliving.org)