

Border Children's Mental Health Collaborative

Criteria for Referral

What is Wraparound?

Wraparound in a family centered, community-oriented, strengths-based, highly individualized planning process aimed at helping people meet their unmet needs both within and outside of formal human services systems, while they remain in their neighborhoods and homes, whenever possible.

Children/Adolescents 5 to 22 years old who are residents of El Paso County and meet the following criteria:

- ✓ A DSM IV Axis I diagnosis other than a single disorder of substance abuse by a psychiatrist, psychologist, LPC, or LCSW within the past 12 months.
- ✓ It has been determined by the child's school district that he/she has a serious emotional disturbance and/or
- ✓ The child/adolescent is at imminent risk of disruption or removal from the home or preferred living situation due to his/her psychiatric disorder and/or
- ✓ Returning from out of home placement in need of transition back to preferred living situation and/or
- ✓ A functional impairment as indicated by a Global Assessment of Functioning (GAF) score of 50 or less, either currently or within the past year.

Please return referral form and supporting documentation to Vashti Pussman, an appointment will be scheduled to staff your case for possible services through BCMHC. You will be notified of date and time of the staffing by telephone/ e-mail. Agency representatives are required to attend staffings. It is highly encouraged for families to attend.

Vashti Pussman
BCMHC Care Management Supervisor
8500 Boeing
El Paso, TX. 79925
(915) 629-2665 ext. 12581
(915) 873-5186 cell
(915) 881-1330 fax
vpussman@epmhm.org

Border Children's Mental Health Collaborative

Date: _____

Name of Youth:

First Name Last Name Middle Initial

Gender: Male Female

D.O.B: _____ Age: _____
 Month/ Day/ Year

Parent/ Guardian Name:

First Name Last Name Middle Initial

Telephone Number: () _____

Referring Agency: _____

Contact Person: _____

Telephone Number: () _____

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Diagnosis	
Medical Conditions:	
Treating Physician:	
Medications:	
Psychological/Psychiatric (if known):	
Axis I: _____	
Axis II: _____	
Axis III: _____	
Axis IV: _____	
Axis V: _____	
Treating Physician:	
Medications:	

Placement History- Attach Supporting Documentation

- | | |
|---|--|
| <input type="checkbox"/> Residential Treatment Center | <input type="checkbox"/> Kinship Care |
| <input type="checkbox"/> Juvenile Detention | <input type="checkbox"/> Foster Care |
| <input type="checkbox"/> Private out of home | <input type="checkbox"/> Temporary out of home placement |
| <input type="checkbox"/> Psychiatric Hospitalization | <input type="checkbox"/> Runaway Shelter |

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Past or Current Services Received-

Indicate whether the services provided are **P= Past** or **C= Current**

Indicate whether the services provided was **S= Successful** **U= Unsuccessful** **P= Progress Made**

Example: C / U

- | | |
|---|--|
| <input type="checkbox"/> Counseling Individual/Family | <input type="checkbox"/> Psychiatric Services |
| <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Medicaid Services |
| <input type="checkbox"/> School Special Education | <input type="checkbox"/> Non-traditional Services |
| <input type="checkbox"/> School (504) | <input type="checkbox"/> Non-Agency Services _____ |

Permanency Plan (CPS ONLY)

- | | | |
|--|---|-----------------------------------|
| <input type="checkbox"/> Reunification | <input type="checkbox"/> Permanent Foster Care | <input type="checkbox"/> Adoption |
| <input type="checkbox"/> Aging out | <input type="checkbox"/> Foster Care Transition | |

Education

- | | |
|-------------------------|---|
| School: _____ | <input type="checkbox"/> Special Education |
| Grade: _____ | <input type="checkbox"/> BIC |
| Date of Last ARD: _____ | <input type="checkbox"/> AIM |
| | <input type="checkbox"/> Advanced Placement |

Pay or Source/Rate:

- Private Insurance # _____
- Medicaid # _____
- Chip _____

MHMR enrollment: Yes No **Date:** _____
(Current or in the past)

Name of Caseworker: _____

