SOUTH CAROLINA continuum of care

Updated 11/22/16

Dear Parent/Legal Guardian:

The Continuum of Care's (COC) philosophy is that children are more successful when served in their families' homes and in their community. COC works to ensure that children with the most severe and complex emotional or behavioral health challenges, whose needs are not being adequately met by existing services and programs, have the services and supports in place to support both youth and family in the least restrictive setting.

COC provides High Fidelity Wraparound care coordination by developing a team to work with your family and your providers as partners in managing your child's care through monthly meetings.

Wraparound has been shown to help avoid out of home placements, improve school attendance and performance, decrease interactions with the legal system, and enhance the overall quality of life for your family. The following information is needed *to apply*:

- The Referral Form;
- Copy of Medicaid card and/or other insurance card; and *a copy of the SSN*
    - Documentation of a child's diagnosis;

After the application information is received by the Regional Office, a COC staff member will contact you to schedule a face to face visit. *With your consent additional providers will be contacted to gather information to help determine your child's needs.* If your child is determined to be eligible, COC will help you assemble your Child & Family Team to begin developing a Plan of Care. Questions regarding the application should be directed to the regional office serving your county of residence.

Sincerely,

Petra Clay Jones, ACSW, LISW-CPS
Director
Continuum of Care
Office of Executive Policy and Programs
The South Carolina Department of Administration
1205 Pendleton Street, Suite 372, Columbia, SC 29201

Updated 11/22/16

STATE OFFICE
1205 Pendleton Street, Suite 372
Columbia, South Carolina 29201
Office: (803)734-4500 Fax: (803)734-4538
Executive Director: Petra Clay-Jones, ACSW, LISW-CPS
Youth & Family Services Director: Vacant

REGIONAL OFFICES AND COUNTIES SERVED

Region A:
Midlands Office 1205 Pendleton Street, Suite 341C
Columbia, South Carolina 29201
Office: (803) 737-1601 Fax: (803) 737-1610
Counties Served: Aiken, Barnwell, Chester, Fairfield, Lancaster, Lexington, Richland, York
Regional Director: LaVernda Ragins,

Region B:
Upstate Office Piedmont Center, East Building 37 Villa Road, Suite 300
Greenville, South Carolina 29615
Office: (864) 271-4321 Fax: (864) 271-4473 C
ounties Served: Abbeville, Anderson, Cherokee, Edgefield, Greenville, Greenwood, Laurens, McCormick, Newberry, Oconee, Pickens, Saluda, Spartanburg, Union
Regional Director: Gregory B. Wright, LPC

Region C:
Pee Dee Office 2120 Jody Road, Suite E
Florence, South Carolina 29501
Office: (843) 317-4021 Fax: (843) 317-4018
Counties Served: Chesterfield, Clarendon, Darlington, Dillon, Florence, Georgetown, Horry, Kershaw, Lee, Marion, Marlboro, Sumter, Williamsburg
Regional Director: Blanchie J. James, LPC

Region D:
Lowcountry Office 7410 Northside Drive, Suite 201
North Charleston, South Carolina 29420
Office: (843) 569-3079 Fax: (843) 569-2403
Counties Served: Allendale, Bamberg, Beaufort, Berkeley, Calhoun, Charleston, Colleton, Dorchester, Hampton, Jasper, Orangeburg
Regional Director: Kimberly Perkins, MS, LPC, NCC

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INITIAL SCREENING CRITERIA
A youth must meet the following initial screening criteria:

- be a legal resident of South Carolina; parent or guardian must remain a resident of South Carolina for the child to continue to be eligible for Continuum services;

- have not yet reached his/her eighteenth (18) birthday or, if 18 or older, be actively attending school or enrolled in a vocational program;

- confirmation of a severe emotional or behavioral health diagnosis documented by a Physician, Licensed Clinical Psychologist, Counseling Psychologist, Licensed Master Social Worker, Licensed Independent Social Worker-Clinical Practice, Licensed Professional Counselor, Licensed Marriage and Family Therapist, Developmental Pediatrician, or Department of Mental Health Licensed Physician;

- have treatment needs which are not being met by the existing service delivery systems and which require a comprehensive and organized system of care which can be met by programs designed to accept and serve children with emotional and behavioral health concerns;

- be in the custody of his or her parents or other legal custodian/guardian;

- an application must be submitted with a signed consent of the parent or guardian; if (18) years or older and competent to do so, the consent must be signed by the youth

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Section 1: Youth Information

Child's Name: _____

Date of Birth: _____ Age: _____ Medicaid? ☐ Yes ☐ No Medicaid #: _____

Medicaid MCO: _____

Private Insurance Name: _____

Youth's Home Address: _____

_____

Youth's Phone: _____ Circle One: Cell Home SSN: _____

If youth is not living with parent/caregiver, give location name & address:

_____

Please list any language barriers the child may have: _____

Child's Gender: ☐ Male ☐ Female ☐ Transgender

Child's Race *(Select All that Apply):* ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American ☐ Hispanic ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Unknown ☐ Declined to Specify

Section 2: Who created this referral for Wraparound?

Referral Date: _____ Agency: _____ Contact Person: _____

Relationship to child: _____ Phone: _____ Email: _____

Address: _____ Fax: _____

Are there other state agencies involved with the care of this child? Select all that apply:

☐ DDSN – Autism Division ☐ DDSN – ID/RD Division ☐ DJJ ☐ DMH ☐ DSS ☐ School

Section 3: Parent/Caregiver Information

Parent/Caregiver 1 Name: _____

Relationship to child: _____

Primary Caregiver? ☐ Yes ☐ No Legal Guardian? ☐ Yes ☐ No Same Address as child? ☐ Yes ☐ No

If no, address: _____

_____

Phone: _____ Is this the same phone number for the child? ☐ Yes ☐ No

If no, what's the best phone number for the child? _____

Parent/Caregiver 1 Email: _____

Do you have legal custody to make decisions on behalf of the youth? ☐ Yes ☐ No

If no, who does? _____

(If proof of legal custody, please attach. COC will request documentation.)

Phone: _____ Phone Type (Circle One): Cell Home Work

Parent/Caregiver 2 Name: _____

Relationship to child: _____

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Primary Caregiver? ☐ Yes ☐ No Legal Guardian? ☐ Yes ☐ No Same Address as child? ☐ Yes ☐ No

If no, address: _____

_____

Phone: _____ Is this the same phone number for the child? ☐ Yes ☐ No

If no, what's the best phone number for the child? _____

Parent/Caregiver 2 Email Address: _____

Do you have legal custody to make decisions on behalf of the youth? ☐ Yes ☐ No

If no, who does? _____

(If proof of legal custody, please attach. COC will request documentation.)

Phone: _____ Phone Type (Circle One): Cell Home Work

Section 4: Educational Information

Currently enrolled in school? ☐ Yes ☐ No Grade: _____ School District: _____

School Name: _____

School Placement: ☐ General Education ☐ Special Education

If Special Education, please select a classification: ☐ ED ☐ LD ☐ OHI ☐ Other: _____

Is the IEP/504 Plan in place? ☐ Yes ☐ No

Section 5: Youth's Medical Information

DSMV/ICD10 Diagnosis(es): _____

_____

Start Date of Diagnosis(es): _____

Who completed this diagnostic assessment? _____

(If assessment is available, please attach)

What date was it completed? _____ Phone: _____

Please list all Medication(s), the dosage, frequency, and the date the child started taking it (them):

_____

_____

_____

_____

Are there currently in home services in place? For example, Behavioral Modification, Family Support Services, or Crisis Intervention Specialist? If so, please list:

_____

_____

Why are you referring this child to Wraparound?

_____

_____

_____

_____

Parent/Caregiver Signature &

☐ **Please check here if no signature above to indicate that Parent/Guardian is unavailable to sign, but has been notified about this referral to COC and will be expecting contact and referral review with COC staff.**