

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
Counties 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

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

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: _____

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.