



The mission of the Continuum of Care (COC) is to ensure continuing development and delivery of appropriate services to those children with the most severe and complex emotional or behavioral health challenges whose needs are not being adequately met by existing services and programs. COC ensures the special needs of our families are met by augmenting existing resources to create a full service array that ensures our youth have access to services and supports needed in order to be served in the least restrictive, most appropriate setting.

We believe it is important to define COC's approach to care coordination and providing services. Our basic philosophy is that children are more successful when served in their families' homes and in their community. If therapeutic admissions are necessary, we strive for solid discharge planning that is short term and ensures return home. We provide care coordination by developing a Team to work with you and your providers as partners in managing your child's care.

The Continuum provides high fidelity Wraparound care coordination for your child and your family. Wraparound is a team based approach involving youth, families, natural supports, and professional service providers, called the Child & Family Team. Through monthly meetings, your Child & Family Team will develop a community-based plan of care that is the best strategy for accomplishing your family's vision and goals. Wraparound is an effective, evidence based process of care coordination and planning that builds on the collective action of this team to assure that youth and families can experience success in their communities, homes, and schools. 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:

- The Referral Form;
- If your child is Medicaid eligible, then a copy of the Medicaid card will be requested at initial meeting;
- Documentation of a child's diagnosis is also needed and would be helpful if submitted at the time of completing the referral. Documentation can be in the form of a physician's statement, copy of a previous evaluation signed by a licensed clinician, Department of Mental Health Physician's Note; copy of a psychological evaluation by a licensed psychologist or Department of Juvenile Justice evaluation.

After the application information is received by the Regional Office, a COC staff member will contact you to schedule a face to face visit. At this initial contact, we will explore the reason for referral and begin assessing for eligibility for Wraparound. If your child is determined to be eligible, within 30 days of securing all supporting documentation, the COC will help you assemble your Child & Family Team to begin developing a Plan of Care. Your Child & Family Team will meet monthly for care coordination in order to support successful outcomes.

It is the intention of COC to assist you throughout the application process. Questions regarding the application should be directed to the regional office serving your county of residence or to the COC's State Office in Columbia at 803.734.4500. Please see the attached list of offices.



**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: Jennifer Gilmore, LMFT, LPC**

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

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

Counties Served: Abbeville, Anderson, Cherokee, Edgefield, Greenville, Greenwood, Laurens, McCormick, Newberry, Oconee, Pickens, Saluda, Spartanburg, Union

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

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



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



Please complete the following information to the best of your ability

Section 1: Youth Information

Child's Name: _____
Last First Middle Suffix

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

Medicaid MCO: _____

Private Insurance Name: _____

Youth's Home Address: _____
Street

City County State Zip

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

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: _____
Street

City State Zip

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: _____



Please complete the following information to the best of your ability

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

If no, address: _____
Street

City _____ State _____ Zip _____

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 & Date

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.