

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 these 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.

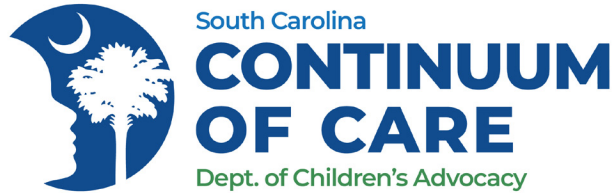
Wraparound has been shown to help avoid out of home placements, improve school attendance and performance, decrease interactions with the legal system, and enhance the overall quality of life for your family. The following information is needed to apply:

- Completed Application
- Referral Form
- Copy of Medicaid card and/or other insurance card
- Copy of the child's Social Security number
- 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,

Gregory B. Wright, LPCS  
Division Director  
Continuum of Care  
Department of Children's Advocacy  
1205 Pendleton Street, Suite 453A, Columbia, SC 29201



## STATE OFFICE

1205 Pendleton Street, Suite 453  
Columbia, South Carolina 29201

**Office:** (803) 734-4500

**Fax:** (803) 734-4538

**Web:** [coc.sc.gov](http://coc.sc.gov)

**Division Director:** Gregory B. Wright, LPCS

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## REGIONAL OFFICES AND COUNTIES SERVED

### Region A: Midlands Office

810 Dutch Square Blvd, Suite 390  
Columbia, South Carolina 29210

**Office:** (803) 737-1601

**Fax:** (803) 737-1610

**Counties Served:**

Aiken, Barnwell, Chester, Fairfield, Lancaster,  
Lexington, Richland, York

### Region C: Pee Dee Office

183 South Coit Street, Suite A  
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

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### 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

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### Region D: Lowcountry Office

4925 Lacross Road, Suite 112  
North Charleston, South Carolina 29406

**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 that are not being met by the existing service delivery systems and which require a comprehensive and organized system of care that 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, other legal custodian/guardian, or the South Carolina Department of Social Services. Youth must be living in the community, relative placement, foster or group home;
- 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: \_\_\_\_\_  Cell  Home SSN: \_\_\_\_\_

If youth is not living with parent/caregiver, give location name and address: \_\_\_\_\_

\_\_\_\_\_

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  Decline 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 not living at the same address as the child, please list address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_  Cell  Home  Work Is this the same phone number for the child?  Yes  No

If not, what is the best number for the child? \_\_\_\_\_ 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)*

Parent/Caregiver 2 Name: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Primary Caregiver:  Yes  No      Legal Guardian  Yes  No      Same Address as Child  Yes  No

If not living at the same address as the child, please list address: \_\_\_\_\_

Phone: \_\_\_\_\_  Cell  Home  Work      Is this the same phone number for the child?  Yes  No

If not, what is the best number for the child? \_\_\_\_\_ 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)*

#### **Section 4: Educational Information**

Currently enrolled in school?  Yes  No      Grade: \_\_\_\_\_ School district: \_\_\_\_\_

School name: \_\_\_\_\_ Phone: \_\_\_\_\_ Email: \_\_\_\_\_

School Placement:  General Education  Special Education      Is an IEP/504 Plan in Place?  Yes  No

If Special Education, please select a classification:  ED  LD  OHI  Other: \_\_\_\_\_

#### **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: \_\_\_\_\_

List all medication(s), dosage, frequency, and the date the child started taking it/them: \_\_\_\_\_

List any in-home services currently in place (ie. family support services, or crisis intervention specialists, etc.)

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.