GUIDE TO WRITING A DISENROLLMENT PLAN OF CARE

A Disenrollment Plan of Care Meeting must be held the month prior to the planned disenrollment date to allow for effective transition planning. If disenrollment occurs unexpectedly, the POC Meeting must be held as soon as possible to ensure the youth and family have a solid understanding of continuing supports.

This guide is designed to supplement routine Plan of Care updates as outlined in the Plan of Care Policy #028.

DEMOGRAPHICS
Addresses and phone numbers must be correct and current. Youth may only be in out of home placement if an order is continuing without Wraparound (and Wraparound has been removed from the court order). All other youth must be at home or with a relative (exceptions are youth disenrolling due to being missing from care or placed in corrections).

Team members listed on the Team and Strengths Lists are those who will continue up to and past disenrollment and who have a role (strategy) in continuing to support the youth and family. It should prominently be comprised of natural, informal and community supports, in addition to the immediate family. If family members are in need of support, in addition to the supports provided directly to the youth, those supports are considered team members as well.

STRENGTHS
Functional Strength List has been updated to match those team members included on Team List.

FAMILY NARRATIVE
As always, Family Narrative updates list what has been helpful for the youth and family, as well as anything that was not effective or helpful. The reason and date of disenrollment should be incorporated into the update.

CRISIS SAFETY PLAN
Crisis/Safety Plan has been updated to reflect involvement of all natural, community, informal supports and paid providers that will continue up to and past disenrollment; specifies contact names, addresses and phone numbers as appropriate. Places in the community that are specific resources the family has been introduced to must be listed and include the name/number of a contact person. These resources must be reflected in steps used later in the Crisis Plan.

VISION
Family Vision is verified and updated as needed to reflect the future dreams of the youth and family.

NEEDS
If High or Medium Domains (as reflected on the Domain Review Checklist) continue to exist, Needs should remain open to allow the continuing Child and Family Team to address these post-disenrollment. If Needs are closed at the Disenrollment Plan of Care Meeting, all strategies under that Need must be updated to outline how remaining team members will maintain the progress that has been accomplished.

BENCHMARKS
Benchmarks are updated, clearly relate to the Needs, and can be measured by anyone looking at the Plan of Care post disenrollment.
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STRATEGIES
Strategies must be updated to reflect the sustainable plan discussed at the Disenrollment Plan of Care Meeting. All natural, community, informal, and continuing paid providers must be incorporated. If paid providers are remaining with the family, there must be a clear outline of how that service will be paid for without Wraparound. For youth taking medications, a transition plan to a continuing provider must be clearly identified, including the date of the next scheduled medication appointment. For those paid providers (including care coordination) continuing up to the disenrollment date, but not beyond, strategies must remain in place detailing their role and responsibilities. It is expected that these center on transition planning and preparedness, as well as clearly state the last date this service will be available to the Child and Family Team.

For youth 18 or over, and living independently: Strategies must clearly spell out how the youth will support themselves (what their income will be), how their basic needs will be met (money/insurance coverage for medications, mental health services, food, rent, supervision) after disenrollment.

For youth or young adults in a correctional placement: Strategies must outline how the family will stay in contact with the youth or young adult by phone and in person, as well as who their contact person at the facility is. Strategies must state what services and supports will be offered by that facility. Strategies also indicate what potential resources have been provided to the youth and/or family that may be useful upon their return to the community.

SPECIAL CIRCUMSTANCES
Referrals to O’YEAH have been made at least two months before a planned “transfer” disenrollment if the team has identified the need for continued involvement in a Wraparound program. Assistance must be provided to help youth contact O’YEAH. Follow-up must occur with O’YEAH so the team is aware of the outcome of their assessment/acceptance prior to disenrollment from the current program. Enrollment in this program is not automatic. Referrals to the appropriate adult resources have been made if the youth is nearing adulthood and needs continued formal supports (Adult Disability Services and/or CARS). A psychological evaluation has been done within the last year for a youth who may need continuing services. The evaluation must include recommendations regarding services beyond age eighteen, as well as an IQ score and updated mental health diagnoses. Referrals can be made to Adult Disability Services for a youth with an IQ of 70 or below when that youth is 17.5 years old. Please consult with the Wraparound Milwaukee Finance Director prior to making a referral. Referrals for youth with chronic mental health needs can be made to the Community Access to Recovery Support (CARS) program when the youth is 17.5 years old. Once a date of enrollment into these programs has been determined, the Wraparound Milwaukee Enrollment Coordinator and Finance Coordinator must be notified. For youth on court orders, the order must be revised to remove Wraparound prior to enrollment in either Adult Services, or within sixty days of enrollment in CARS. Wraparound and CARS are able to overlap for a maximum period of sixty days to allow for transition. Overlap is not allowable with Adult Services. These services must be clearly reflected in the strategies. For youth on a CHIPS order, the OCM must complete the referrals for adult programming. For any other youth, the Care Coordinator is responsible for facilitating this with the youth and family.