New York State
High Fidelity Wraparound (HFW) Agreement Form

Agreement Date (mm/dd/yyyy): _____ **CIN Number:** _____

MEMBER (CHILD/YOUTH)

Name: _____ **Date of Birth** (mm/dd/yyyy): _____

PARENT/GUARDIAN/LEGALLY AUTHORIZED REPRESENTATIVE (Required if youth cannot consent for themselves)

Name: _____

CARE MANAGEMENT AGENCY/HEALTH HOME

Name: _____

Address: _____

Telephone Number: _____

High Fidelity Wraparound (HFW) is a process that helps youth, and their families to meet their needs and achieve their vision for the future. The process brings together a team that focuses on the strengths of the family and aims to ensure the youth's success at home, in school, and in the community.

What should youth and family expect when participating in HFW?

- You will be treated as the experts on your family. HFW is not about what anyone believes you should be doing. It's about supporting you to reach your vision.
- You will select and approve each member of your team.
- Your care manager will guide you through this process. You can expect to have contact with your care manager multiple times per month and upon your request.
- Your care manager will spend time getting to know you and discussing your strengths, needs, concerns, hopes, and dreams for the future.
- HFW supports the entire family, not just the youth. Each member will play an active role in this process.
- Your team will meet monthly to discuss progress.
- You will be respected, and your voice will be heard.

By signing this form, I understand that:

- Participating in High Fidelity Wraparound is voluntary, and I would like to participate.
- The NYS Office of Mental Health and the NYS Department of Health want to learn how the High Fidelity Wraparound process is working to help youth and families.
  - To do this, information will be gathered from the assigned High Fidelity Wraparound care manager and from the electronic health record of the participating youth. This information will be used to understand if the program is effective for youth and families, and to improve High Fidelity Wraparound for future youth and families seeking services. This information with be kept confidential and secure and used in accordance with Health Home Consent Form DOH-5201 and in accordance with the law.
- I can stop participating in High Fidelity Wraparound at any time, by notifying my High Fidelity Wraparound care manager or lead Health Home.

High Fidelity Wraparound Care Manager's Name (Print)**:** _____

High Fidelity Wraparound Care Manager's Signature: _____

Date: _____

Member Signature or Parent/Caregiver Signature: _____
(Required if youth cannot consent for him/herself, e.g., under 18 years of age)

Date: _____