Carroll County Local Care Team (LCT) Referral Form
Authorization for Interagency Release of Information/Records

Parent(s)/Guardian(s) Name(s): _____ **DOB:** _____

Name of Youth: _____ **DOB:** _____

A SEPARATE REFERRAL MUST BE COMPLETED FOR EACH CHILD/YOUTH REFERRAL

I/We give my/our permission for my/our family to be referred to the Carroll County Local Care Team (LCT). I/we understand that the LCT is comprised of various state, county, and local agencies and organizations concerned primarily with the provision of services to children and families. I/We understand that if I/we wish to exclude any of the LCT members listed below from being involved in our referral, I/we must notify the LCT Coordinator prior to the meeting to exclude those members. **Members that may be in attendance include:**

Access Carroll
Boys& Girls Club
Carroll Hospital/LifeBridge Health
Carroll County Public Schools
Carroll County Youth Service Bureau
Catastrophic Health Planners
Department of Citizen Services
Department of Juvenile Services
Department of Social Services
Developmental Disabilities Admin.
Division of Rehabilitation Services
Health Department/Nursing Bureau
Life Renewal Services
Local Behavioral Health Authority
Local Management Board
McDaniel College
Maryland Coalition of Families
Potomac Case Management Svcs.
Springboard Community Svcs.

List other Agencies/Organizations who may help with the family's action plan:

_____

I/We understand that this form authorizes appropriate partnership between family members and LCT members during which family information will be exchanged and released. I/We understand that information obtained will be used to plan for the delivery of appropriate services for my/our family and for program evaluation.
The information to be obtained may include records pertaining to:

SELECT ALL THAT APPLY:

- ☐ *Developmental History*
- ☐ *Discharge Summaries*
- ☐ *Educational Information*
- ☐ *Juvenile Services Information*
- ☐ *Medical History*
- ☐ *Medication Administration Records*
- ☐ *Psychiatric Diagnoses & Reports*
- ☐ *Psychological Evaluations*
- ☐ *Social Services*
- ☐ *Treatment Plans*
- ☐ *Other:* _____
- ☐ ***ALL OF THE ABOVE***

I/We understand that authorizing this disclosure of information is voluntary. I/We understand that I/we have a right to revoke this authorization at any time. I/We understand that the revocation will not apply to information that has already been released in response to this authorization. I/We understand that if I/we revoke this authorization that it must be done in writing and presented to the Carroll County Local Care Team. **This consent expires two (2) years from the date signed unless otherwise specified in the space that follows:** _____

I (We) understand that MD is a mandatory child abuse/neglect reporting state and that child service providers, among others, are required to report if child abuse or neglect is evident or suspected (Family Law § 5-704).

Parent/Guardian 1 Signature	**Date**	**Witness/LCT Member Name**
Parent/Guardian 2 Signature	**Date**	**Witness/LCT Member Signature**

The Americans with Disabilities Act applies to the Carroll County Government and its programs, services, activities, and facilities. Anyone requiring an auxiliary aid or service for effective communication or who has a complaint should contact The Department of Citizen Services, 410.386.3600 or 1.888.302.8978 or MD Relay 7-1-1/1.800.735.2258 or email ada@carrollcountymd.gov as soon as possible but no later than 72 hours before the scheduled event.

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Referral Instructions and Responsibilities for the Local Care Team and the Family

Instructions:

- Please complete this 9-page form to make a referral to the Carroll County Local Care Team (LCT). Answers are required for items marked with an asterisk (*).
- Parents/caregivers completing the form should provide as much information as possible. Local Care Team Coordinators will assist with completing the form as needed to ensure all relevant information is obtained.
- Forms must be transmitted securely which may include using encryption to ensure the confidentiality of protected health information (PHI) such as encryption via Microsoft Outlook, Virtru, or other software.
- Consents and releases should be obtained as necessary (see page 1).
- You can access the Maryland Local Care Team Directory at https://gocpp.maryland.gov/wp-content/uploads/LCT-Directory.pdf.

LCT Responsibilities:

1. The LCT is the central point for coordinated case management and access to services for children and youth.
2. LCT meetings help identify potential resources and facilitate access to community-based services for children and families with intensive needs. Meetings typically result in the creation of a Family Action Plan.
3. The LCT also independently reviews Voluntary Placement Agreements (VPAs) from the Department of Social Services (DSS) and recommendations for out-of-home placement and ensures all relevant community-based services have already been utilized.
4. These services provided by the LCT are free to Carroll County residents with children.
5. The LCT will make every effort to hold a LCT meeting within five (5) days of receiving a completed referral.
6. The LCT will not hold a meeting without the parent(s)/caregiver(s) present or their agreement to hold the meeting without them.
7. Information shared during or for the purposes of the LCT meeting will be kept confidential with the exceptions of case management activities, quality improvement/program evaluation purposes, and under mandated reporting circumstances (i.e., risk of harm to self or others, suspected abuse).
8. The LCT does not provide emergency or crisis management services. Should an emergency occur, it is important for families to have a crisis plan which might include calling their **current treatment provider**, **988, 911**, or the **Mobile Crisis Team at 410-952-9552** to obtain emergency assistance.

Family Responsibilities:

1. Families of children with intensive needs in Carroll County can be referred or self-refer themselves to the LCT.
2. The family's involvement with the LCT is voluntary. Children and youth are welcome to attend part of or the entire LCT meeting to share their experiences and have an opportunity to advocate for themselves. Discretion by the family and referring entity should be used when considering inviting children or youth to participate.
3. Family Action Plans are typically created during LCT meetings with families. Open communication between the family and the LCT members is critical to the success of the Plan.
4. The family shall remain open to implementing the least restrictive level of service available (such as community-based services instead of potential out-of-home placements).
5. If there are any questions regarding the LCT or its process, the family can contact the LCT Coordinating Team at **localcareteam@carrollcountymd.gov** or **410-386-3615**.

_____	_____	_____
Parent/Caregiver 1 Signature	**Date**	**Witness/LCT Member Name**
_____	_____	_____
Parent/Caregiver 2 Signature	**Date**	**Witness/LCT Member Signature**

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REFERRING INDIVIDUAL OR ENTITY:

***Your name:**_____ ***Date:** _____

***Your relationship to the youth being referred:**

☐ Parent/Guardian ☐ Hospital Personnel ☐ Staff of LCT Member Agency

☐ Other: _____

***Your phone number:** _____ ***Your E-mail:** _____

***Your agency/affiliation**:_____

Provide agency affiliation of person completing referral OR name of hospital where person completing referral is employed.

REFERRED YOUTH'S BASIC INFORMATION:

***Name of youth:** _____ **Youth's age:** _____

***Youth's date of birth (DOB):** _____

***Youth's gender:** ☐ **Boy** ☐ **Girl** ☐ **Transgender Boy** ☐ **Transgender Girl** ☐ **Gender Queer** ☐ **Prefer Not to Answer**

Youth's pronouns: ☐ **he/him/his** ☐ **she/her/hers** ☐ **Prefer Not to Answer** **Other:** _____

***Youth's race: Mark all that apply.** ☐ **American Indian or Alaska Native** ☐ **Asian** ☐ **Black or African American** ☐ **Native Hawaiian or Pacific Islander** ☐ **White** ☐ **Prefer Not to Answer**

***Youth's ethnicity:** ☐ **Hispanic/Latinx or Spanish Origin** ☐ **Not of Hispanic/Latinx or Spanish Origin** ☐ **Prefer Not to Answer**

What language is primarily spoken in the home? _____

***Is Youth a Carroll County resident?** ☐ **Yes** ☐ **No** ***Is Youth a Maryland resident?** ☐ **Yes** ☐ **No**

***Youth's current address:** _____

Facility Name if applicable. Leave this blank for a residence.

_____

Street

_____

City *State* *Zip Code*

***What is Youth's legal status?** ☐ **Committed to an Agency (List the agency below)**

☐ **Co-Committed to Multiple Agencies (List below)** ☐ **Not committed to an Agency**

☐ **Approved Voluntary Placement Agreement** ☐ **Unsure**

**If Committed or Co-committed to Multiple Agencies, please list:*

_____

_____

**Is Youth currently eligible for Medical Assistance?* ☐ *Yes - MA#* _____ ☐ *No* ☐ *Unsure*

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REFERRED YOUTH'S EDUCATIONAL INFORMATION:

***Is youth currently enrolled in school?** ☐ Yes ☐ No **Current grade**?_____

School: _____
Name

_____
School City *School County* *School State*

Educational Goal: ☐ Diploma ☐ GED ☐ Certification of Completion
☐ **Other**:_____

If NOT currently enrolled in school, what was the last school attended?

_____
School Name *School City* *School State*

If NOT currently enrolled in school, what was the last grade completed? _____

If NOT currently enrolled in school, list the Withdrawal or Graduation Date: _____

Date last IEP completed, if applicable: _____

Educational Code - Include information on youth's primary disability as identified on their Individualized Education Program Plan.
Select ALL that apply:

☐ **01** Autism
☐ **02** Deaf
☐ **03** Deaf - Blindness
☐ **04** Developmental Delay
☐ **05** Emotional Delay
☐ **06** Hearing Impairment
☐ **07** Intellectual Disability
☐ **08** Orthopedic Impairment
☐ **09** Other Health Imp6irment
☐ **10** Specific Learning Disability (Dyslexia, Dysgraphia, Dyscalculia)
☐ **11** Speech or Language Impairment
☐ **12** Traumatic Brain Injury
☐ **13** Visual Impairment
☐ **14** Multiple Disabilities (Cognitive, Sensory, Physical)

Date last 504 Plan completed, if applicable: _____

ATTENDANCE INTERVENTION – If the child/youth is being referred for truancy concerns, this page should be completed by the appropriate CCPS PPW.

Percentage History of Attendance:

Kindergarten: _____ Grade 3: _____ Grade 6: _____ Grade 9: _____ Grade 12: _____

Grade 1: _____ Grade 4: _____ Grade 7: _____ Grade 10: _____

Grade 2: _____ Grade 5: _____ Grade 8: _____ Grade 11: _____

Current Attendance:

Schools Attended	Grade Level	Days of School Missed	Days Tardy To School

CCPS Attendance Interventions:

_____

_____

_____

Community Based Services (Past and/or Present) Related to Attendance:

_____

_____

Additional Family Concerns Related to Attendance:

_____

_____

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REFERRED YOUTH'S PARENT/GUARDIAN INFORMATION:

***Name of Legal Guardian #1:** _____

***Relationship to child/youth:** _____

***Phone number:** _____

***Email:** _____

***Address of Legal Guardian #1:** _____

_____

***County of Legal Guardian #1:** _____

Name of Legal Guardian #2: _____

Relationship to child/youth: _____

Phone Number: _____

Email: _____

Address of Legal Guardian #2: ☐ **SAME AS THE ABOVE ADDRESS. If not, provide address:**

_____

_____

County of Legal Guardian #2: _____

Have parental rights been terminated? ☐ Yes ☐ No ☐ N/A

If yes, list the names of the parent(s) whose rights were terminated:

Parent Name: _____
Relationship to child/youth

Parent Name: _____
Relationship to child/youth

***Please list all members of child's current household (attach an additional page if necessary):**

Name: _____ Age:_____ Relationship:_____

Name: _____ Age: _____ Relationship:_____

Name: _____Age: _____ Relationship:_____

Name: _____ Age: _____ Relationship:_____

Name: _____ Age: _____ Relationship: _____

***Is the family experiencing food, housing, financial, or transportation instability?** ☐ Yes ☐ No ☐ Unsure

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REFERRED YOUTH'S ADDITIONAL INFORMATION:

	Yes, Currently	No, but Prior	Never	N/A
Developmental Disability Diagnosis	☐	☐	☐	☐
Multiple Mental Health Diagnoses	☐	☐	☐	☐
Aggressive Behaviors	☐	☐	☐	☐
Sexually Reactive Behaviors	☐	☐	☐	☐
Suicidal Ideation	☐	☐	☐	☐
Suicide Attempt	☐	☐	☐	☐
Fire Setting	☐	☐	☐	☐
Substance Use	☐	☐	☐	☐
Pregnant or Parenting	☐	☐	☐	☐
Denied RTC Placement NOT Due to Bed Availability	☐	☐	☐	☐

YOUTH INPUT: Ask the youth to describe what is going well for them at home and in school and what would they like to see improve. What resources would help to make their current situation better?

_____

_____

_____

_____

***REFERRING ENTITY/PARENT/GUARDIAN: Describe present issues/reason you are seeking services.**

_____

_____

_____

_____

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***Provide an overview of the youth's strengths (attach an additional page if necessary):**

***Provide an overview of the youth's clinical needs (attach an additional page if necessary):**

***List current diagnosis and current medications:**

Services received from/agency involvement:	**Yes, Currently**	**No, but Prior**	**Never**	**N/A**
Department of Social Services	☐	☐	☐	☐
Department of Juvenile Services	☐	☐	☐	☐
Developmental Disabilities Administration	☐	☐	☐	☐
Local Behavioral Health Authority	☐	☐	☐	☐
Private Behavioral Health Provider	☐	☐	☐	☐

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Is the youth currently receiving counseling services? ☐ Yes ☐ No **If yes, list the name of the provider:**

_____

Please list other services received, both past and present.

Name of Agency/Private Provider	Service Provided	Dates of Service

Services currently recommended for child/youth:

	Yes	No	N/A
Counseling/Therapy	☐	☐	☐
Psychological Evaluation	☐	☐	☐
Substance Use Treatment	☐	☐	☐
Sex Offender Treatment	☐	☐	☐
Behavioral Supports	☐	☐	☐
Medication Monitoring	☐	☐	☐
Psychiatric Services	☐	☐	☐
Substance Use Education	☐	☐	☐
Fire Setter Treatment	☐	☐	☐
Medical Care	☐	☐	☐
Trauma-Based Therapy	☐	☐	☐
Psychosocial Evaluation	☐	☐	☐
Neurological Evaluation	☐	☐	☐

Has the child/youth previously been referred to the LCT? Yes ☐ No ☐ Unsure ☐

If yes, when was the LCT meeting held? _____

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***Is youth currently in a hospital and overstaying medical necessity?** ☐ Yes ☐ No

***Is a residential placement clinically recommended?** ☐ Yes ☐ No ☐ Unsure

IF YES:

What is the Level of Care recommended (e.g., group home, RTC, inpatient hospital)?

_____

_____

*Who is the individual making the recommendation (e.g., youth's psychiatrist, CRNP, therapist)?_____

Is this a new placement or a transfer between similar settings? ☐ New ☐ Transfer

Have in-State resources been explored for the residential placement? ☐ Yes ☐ No

***What is the clinical recommendation?**

_____

_____

_____

_____

_____

If in-State resources were NOT explored for the residential placement, explain the reasons why below, including the specific services that are not available for in-State programs to be considered:

_____

_____

_____

_____

_____

Exception criteria for Out-of-State (OOS) Placement:

- **Closer:** The OOS placement is closer to the youth's home than any alternative in-state placement.
- **Proximity:** Youth's permanent placement includes residence with caregiver in proximity to proposed OOS placement
- **Cost:** The individualized needs of the youth cannot be met through available, appropriate in-state resources at a total cost less than or equal to 100% of the average cost per placement for all appropriate OOS programs.
- **Detention:** The youth is currently in detention, shelter care, or committed to the Department of Juvenile Services (DJS) pending placement under a court order.
- **DEA:** Compliance with the federal individuals with Disabilities Education Act (IDEA) requires OOS.
- **Hospital:** The youth is hospitalized in an acute care psychiatric hospital under the following circumstances:
    1. Committed to DJS, local DSS, or a division of MDH;
    2. The treatment team has determined that the youth is ready for discharge; and
    3. The only available appropriate placement is OOS.

***Is a Voluntary Placement Agreement being considered?** ☐ **Yes** ☐ **No**

Most Recent Placement:

_____
Facility Name

_____
Street Address

_____
City *State* *Zip Code*

Preceding prior placement:

_____
Facility Name

_____
Street Address

_____
City *State* *Zip Code*

What is the expected date of placement? _____

If the youth is currently placed, what is the expected date of discharge? _____

Other Information:

_____

_____

_____

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GUESTS AND INVITEES TO THE LCT MEETING:

***Do you (referring entity) or the family wish to invite guests to this LCT meeting?** ☐ Yes ☐ No

IF YES, the information requested below must be provided:

- The LCT Coordinator will only invite current LCT members (listed on page 1), the referring individual/entity, and with the approval of the parent/guardian, the individuals whose information is listed below.

Name: _____ Email Address: _____

Phone: _____ Agency: _____

Name: _____ Email Address: _____

Phone: _____ Agency: _____

Name: _____ Email Address: _____

Phone: _____ Agency: _____

Name: _____ Email Address: _____

Phone: _____ Agency: _____

Name: _____ Email Address: _____

Phone: _____ Agency: _____

Name: _____ Email Address: _____

Phone: _____ Agency: _____

List other relevant information (attach any additional information if necessary):

_____

_____

_____

_____

_____

_____

_____

_____

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