Carroll County Local Care Team (LCT) Referral Form

Authorization for Interagency Release of Information/Records

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

Child or Children's Name(s): _____ **DOB**: _____

_____ **DOB**: _____

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:**

- Health Department/Nursing Bureau
- Local Behavioral Health Authority
- Carroll Hospital/Lifebridge Health
- Developmental Disabilities Administration
- Together We Own It
- Springboard Community Services
- Local Management Board
- Carroll County Public Schools
- Department of Juvenile Services
- Division of Rehabilitation Services
- Potomac Case Management Svcs.
- Access Carroll
- Maryland Coalition of Families
- Department of Citizen Services
- Carroll Co. Youth Service Bureau
- Department of Social Services
- Get Connected Family Resource Ctr
- Life Renewal Services
- Catastrophic Health Planners
- McDaniel College

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:

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

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**

Carroll County Local Care Team (LCT) Referral Form

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). In order to streamline the referral process, 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 HERE.

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.
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 to invite 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 **410-386-3600**.

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 Local Care Team Member Agency
- ◯ Other: _____

Your phone number: * _____ **Your Email:** *_____

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

Youth's gender: * _____ **Youth's pronouns:** _____

Youth's race: * _____ **Youth's ethnicity:** * _____

Diagnoses and/or disabilities of youth: _____

_____

What language is primarily spoken at home? _____

Youth's county of residence: * _____ **Is Youth a Maryland resident?** * _____

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: _____
- ◯ Co-Committed to Multiple Agencies: _____
- ◯ Not Committed to an Agency
- ◯ Approved Voluntary Placement Agreement
- ◯ Unsure

Is Youth currently eligible for Medical Assistance? * ◯ Yes, MA#: _____ ◯ No ◯ Unsure

REFERRED YOUTH'S EDUCATIONAL INFORMATION

Is youth currently enrolled in school? * ◯ Yes, current grade: _____ ◯ No ◯ Unsure

If currently enrolled in school: _____
School Name

_____
School City *School County* *School State*

Youth's resident school system: _____

Educational Goal:
- ◯ Diploma
- ◯ GED
- ◯ Certificate of Completion
- ◯ Other: _____

Date last IEP completed, if applicable: _____

Educational Code – Include information on youth's primary disability as identified on their Individualized Education Program plan.

- ☐ **01** Autism
- ☐ **02** Deaf
- ☐ **03** Deaf – Blindness
- ☐ **04** Developmental Delay
- ☐ **05** Emotional Disability
- ☐ **06** Hearing Impairment
- ☐ **07** Intellectual Disability
- ☐ **08** Orthopedic Impairment
- ☐ **09** Other Health Impairment
- ☐ **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: _____

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

_____
School Name

_____
School City *School State*

Educational Goal Completed:
- ◯ Diploma
- ◯ GED
- ◯ Certificate of Completion
- ◯ Other: _____

Withdrawal or Graduation Date: _____

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REFERRED YOUTH'S PARENT/GUARDIAN INFORMATION

Have parental rights been terminated?	**Yes**	**No**	**N/A**	*If yes, names of those with terminated rights:*
Mother #1	◯	◯	◯	_____
Mother #2	◯	◯	◯	_____
Father #1	◯	◯	◯	_____
Father #2	◯	◯	◯	_____

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

Name of Legal Guardian #1: * _____

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

Address of Legal Guardian #1: * _____

_____

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

Name of Legal Guardian #2: _____

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

Address of Legal Guardian #2: _____

_____

County of Legal Guardian #2: _____ **Email:** _____

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: _____

Name: _____ Age: _____ Relationship: _____

Name: _____ Age: _____ Relationship: _____

REFERRED YOUTH'S ADDITIONAL INFORMATION:

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

YOUTH INPUT: Ask the youth to describe below their situation/recent events and what their goals are (attach an additional page if necessary):

Describe in detail why you (referring entity) are seeking services and what your goals are (attach an additional page if necessary): *

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): *

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	◯	◯	◯	◯

Please list other services received, both past and present. Use the name of the agency or of the private provider and the dates of service:

Services currently recommended:	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	◯	◯	◯

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

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.

☐ **IDEA:** Compliance with the federal Individuals with Disabilities Education Act (IDEA) requires OOS placement.

☐ **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/or
3. The only available appropriate placement is OOS.

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

Most recent prior placement: _____
Facility Name

_____
Street Address

_____
City *State* *Zip*

Preceding prior placement: _____
Facility Name

_____
Street Address

_____
City *State* *Zip*

Preceding prior placement: _____
Facility Name

_____
Street Address

_____
City *State* *Zip*

What is the expected date of placement? _____

What is the expected date of discharge if youth is currently placed? _____

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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:

- **Please list the names and contact information for invitees below. To ensure more efficient coordination of LCT meetings, please include each individual's email address (if applicable).**
- **The LCT Coordinator will only invite current LCT members, the referring individual/entity, and the individuals whose information is listed below.**
- **You should only list individuals for whom there is written consent from the parent/guardian to invite to the LCT meeting.**

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: _____

Other relevant information (attach an additional page if necessary):