State of Maryland Local Care Team and Interagency Placement Committee Referral Form

Effective March 1, 2021

Instructions

- Please complete the form to make a referral to the Local Care Team in a specific jurisdiction or to the Interagency Placement Committee.
- Parents/caregivers who are completing the form should provide as much information as possible. The Local Care Team coordinator will assist with completing the form as needed to ensure all relevant information is obtained.
- Forms must be transmitted using appropriate encryption to ensure the confidentiality of protected health information.
- Consents and releases should be obtained as necessary.
- For a referral to the Local Care Team, complete the form and send it to the Local Care Team coordinator in the youth's county of residence. Access the Local Care Team Directory here for that information or to contact the coordinator with questions.
- For a referral to the Interagency Placement Committee, complete the form and send it to the Committee via email at: ipc.information@maryland.gov.

Name of Person Completing Form *

First Name Last Name

Are You: *

- ◯ Parent/Guardian
- ◯ Hospital Personnel
- ◯ Staff of Local Care Team Member Agency
- ◯

If "Other", Please Explain Your Relationship to the Youth

Your Phone Number *

Please enter a valid phone number that can be used to contact you regarding this referral.

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Your Email *

example@example.com

Agency/Hospital

For referrals completed by agency/hospital personnel, provide the agency affiliation of the person completing the referral or the name of the hospital where the person completing the referral is employed.

Date Form Completed. *

Month Day Year

Name of Youth *

First Name Middle Name Last Name Suffix

Youth's Date of Birth *

Month Day Year

Youth's Gender *

Youth's Race *

Youth's Ethnicity *

Youth's Current Address *

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Facility Name, if Applicable. Leave this line blank for a residence.

Street Address

Is Youth a Maryland Resident? *

- Yes
- No
- Unsure

What is the Youth's County of Residence? *

What is the Youth's Legal Status? *

- Committed to an Agency (List the Agency Below)
- Co-Committed to Multiple Agencies (List the Agencies Below)
- Not Committed to an Agency
- Approved Voluntary Placement Agreement
- Unsure

If the Youth is Committed to an Agency/Agencies, List Agency or Agencies

Is the Youth Currently Eligible for Medical Assistance? *

- Yes
- No
- Unsure

If the Youth is Currently Receiving Medical Assistance, Enter MA Number Below

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Is the Youth Currently Enrolled in School? *

- ◯ Yes
- ◯ No
- ◯ Unsure

Current Grade if Enrolled

If Currently Enrolled in School:

School Name

City

State

Jurisdiction of School Where the Youth is Enrolled

Educational Goal

- ◯ Diploma
- ◯ GED
- ◯ Certificate of Completion
- ◯

Date Last IEP Completed

Month Day Year

Educational Code - Include Information on the Child/Youth's Primary Disability as Identified on the Youth's Individualized Education Program Plan.

- ☐ 01 Autism
- ☐ 02 Deaf
- ☐ 03 Deaf - Blindness

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- [ ] 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
- [ ] 13 Traumatic Brain Injury
- [ ] 14 Visual Impairment
- [ ] 15 Multiple Disabilities (Cognitive, Sensory, Physical)

Date Last 504 Plan Completed

Month Day Year

What is the Youth's Resident School System?

If Not Currently Enrolled in School, What is the Last School Attended?

Name of Last School Attended

City State

Educational Goal Completed

- ○ Diploma
- ○ GED
- ○ Certificate of Completion
- ○

Withdrawal or Graduation Date

Month Day Year

Withdrawal Grade

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Have Parental Rights Been Terminated?

	Yes	No	N/A
Mother #1	○	○	○
Mother #2	○	○	○
Father #1	○	○	○
Father #2	○	○	○

If Parental Rights Have Been Terminated, List Name of Parent(s) Whose Right(s) Were Terminated

Name of Legal Guardian #1 *

Prefix | First Name | Middle Name | Last Name | Suffix

Relationship to Child/Youth

Address of Legal Guardian #1

Street Address

Street Address Line 2

City | State

Zip Code

County of Address of Legal Guardian #1

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Legal Guardian #1 Email

example@example.com

Phone Number of Legal Guardian #1

Please enter a valid phone number.

Name of Legal Guardian #2

Prefix | First Name | Middle Name | Last Name | Suffix

Relationship to Child/Youth

Address of Legal Guardian #2

Street Address

Street Address Line 2

City | State

Zip Code

County of Address of Legal Guardian #2

Legal Guardian #2 Email

example@example.com

Phone Number of Legal Guardian #2

Please enter a valid phone number.

Additional Information Regarding the Child/Youth:

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	Yes, Currently	No, but Prior	Never	N/A
Has a Child	◯	◯	◯	◯
Pregnant	◯	◯	◯	◯
One or Both Parents Deceased	◯	◯	◯	◯
Gang Affiliated	◯	◯	◯	◯
One or Both Parents Incarcerated	◯	◯	◯	◯
One or Both Parents Substance Use/Abuse History	◯	◯	◯	◯
Lead Exposure	◯	◯	◯	◯
Substance Exposed Newborn	◯	◯	◯	◯
One or Both Parents Mental Health History	◯	◯	◯	◯

Provide an Overview of the Youth's Strengths *

Provide an Overview of the Youth's Clinical Needs *

Services Received From/Agency Involvement:

	Yes, Currently	No, but Prior	Never	Applied
Department of Social Services	◯	◯	◯	◯
Department of Juvenile Services	◯	◯	◯	◯
Developmental Disabilities Administration	◯	◯	◯	◯
Local Behavioral Health Authority	◯	◯	◯	◯
Private Behavioral Health Provider	◯	◯	◯	◯

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Please List Services Received Past and Present. Use the Name of the Agency Listed Above or Private Provider and Dates of Service.

What is the Clinical Recommendation? *

Services Currently Recommended:

	Yes	No	N/A
Counseling/Therapy	◯	◯	◯
Psychological Evaluation	◯	◯	◯
Substance Abuse 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 the Youth Currently in a Hospital and Overstaying Medical Necessity? *

◯ Yes

◯ No

Is a Residential Placement Clinically Recommended? *

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- ○ Yes
- ○ No
- ○ Unsure

If Yes, What is the Reason for Recommending a Residential Placement? *

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 Language is Primarily Spoken at Home?

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.

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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 - The youth's permanent placement includes residence with a caregiver in proximity to the 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

Preceeding Prior Placement

Facility Name

Street Address

City

State

Preceeding Prior Placement

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Facility Name

What is the Expected Date of Placement?

Month Day Year

What is Expected Date of Discharge if Youth is Currently Placed?

Month Day Year

Other Information:

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Charles County Local Care Team

Authorization to Release and Exchange Confidential Information

Child's Name: _____

Child's Date of Birth: _____

I authorize the release and exchange of information between all members of the Local Care Team, to include: the Department of Juvenile Services; the Developmental Disabilities Administration; Substance Abuse Services; the Behavioral Health Administration or the local Core Service Agency; the local School System; the local Health Department; the local Department of Social Services; Parent Advocate; Interagency Placement Committee and the Local Management Board.

The information may include, but is not limited to:

- involvement with community agencies and organizations
- progress in treatment and or placement
- attendance and compliance with programs
- diagnosis
- dates of admission and discharge
- treatment plans
- evaluations
- discharge summary
- recommendations

Please specify any limitations to the exchange and release of information: _____

The purpose of the disclosure authorized herein is to facilitate: (Please check those applicable)

☐ Interagency discussion and problem solving for individual child and family needs

☐ Voluntary Placement Agreement

It is understood that this authorization expires one year from the date signed.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Signature of Youth (if applicable) Date

Return to Charles County Advocacy Council for Children, Youth, and Families
at the Department of Community Services
8190 Port Tobacco Rd
Port Tobacco, Md 20677
CCACCYF-LMB@charlescountymd.gov

LCT & SCC 10-DAY WAIVER

Child		**DOB**	
Jurisdiction		**Lead Agency**	

The Local Care Team (LCT) is a forum for interagency discussions and problem solving for individual child and family needs and systemic needs. Although the LCT does not make residential placement decisions nor is LCT approval required for residential placements, in the course of the interagency discussions, an out-of-State residential placement may be explored, resulting in the LCT making a recommendation to the Lead Agency that a residential placement be considered.

The State Coordinating Council (SCC) reviews applications from Lead Agencies for funding of the residential placement of children with disabilities into residential facilities out of State. The SCC may approve, modify, or reject the application as submitted.

In accordance with Maryland law (Maryland Human Services Article, Section 8-409), parents and attorneys are entitled to written notification at least ten (10) days prior to any meeting of the LCT or SCC in which their child/client's out-of-State placement is discussed.

If you waive your right to a full ten (10) days notice (by signing below), the review of your child/client's case may be expedited. **You must provide a working phone number for your case to be expedited, so that you may be notified of the meeting.** In any event, you will be notified in writing of any decisions of the LCT and/or SCC concerning your child's placement.

This form is optional. If you do not sign this form, your child/client's case will be reviewed by the LCT and/or SCC after providing ten (10) days written notice to you.

I wish to be notified in advance of the date of the Local Care Team or State Coordinating Council meeting to discuss my child/client. I have had an opportunity to review and discuss this form with my child/client's case manager. I do *not* need ten (10) days written notice for the (please check the appropriate box below):

☐ **LCT and SCC meetings** ☐ **LCT meeting only** ☐ **SCC meeting only**

Print name (parent/ guardian/ attorney)			
Please complete a parent or legal guardian *AND* attorney waiver if you'd like to expedite a case review.			
I am the child's	☐ parent	☐ legal guardian	☐ attorney
Phone numbers	Home	Work	Other

This waiver will expire 1 year from the date of the parent/guardian/attorney's signature. This waiver may be rescinded prior to this expiration date by submitting a written letter to the Lead Agency of the intent to withdraw this waiver. The date of Lead Agency's receipt of this letter will be the effective date of the termination of this waiver; the Lead Agency is responsible for notifying the LCT and/or SCC in writing of any waivers withdrawn for LCT and/or SCC cases.

_____

Parent/Guardian/Attorney Signature ***Date***

Lead Agency Verification:

_____

Lead Agency Worker - Print Name ***Signature*** ***Date***