Frederick County Local Care Team (LCT) and Interagency Placement Committee (IPC) Referral Form

Date of LCT Meeting (to be completed by LCT staff) :_____

Instructions

- Please complete this form to make a referral to the Local Care Team or the Interagency Placement Committee.
- Please contact the Local Care Team Coordinator to discuss case to ensure referral is appropriate, **LCT@FrederickCountyMD.gov** or via phone: **301.600.1077**.
- Once deemed appropriate, complete the referral to the Local Care Team and send to the Local Care Team Coordinator: LCT@FrederickCountyMD.gov.
- Parents/advocates who are completing the form should provide as much detail 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 will be obtained as necessary.
- For a referral to the Interagency Placement Committee (IPC), complete the form and send it to the committee via email at ipc.information@maryland.gov.

First Referral to LCT?* Yes☐ No☐ If not, date: _____

Date Form Completed:* _____

Purpose of Meeting:* Technical Assistance _____ VPA (out of home placement) _____

Name of person completing form:*

_____ _____
First Name *Last Name*

Are You*

- ◯ Parent/Guardian
- ◯ Hospital Personnel
- ◯ Staff of Local Care Team Member Agency
- ◯ Other, please explain:

*If not parent referring, were they notified of LCT meeting? Yes ____ No ____ Are they attending? Yes ____ No ____

Your Phone Number* _____
Please enter a valid phone number that can be used to contact you regarding this referral.

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.

What is AGENCY'S expected outcome of meeting?*

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Name of Youth*

_____ _____ _____ _____
First Name *Middle Name* *Last Name* *Suffix*

Youth's Date of Birth* _____ **Youth's Age*** _____ **Primary language*** _____

Youth's Gender* _____

Youth's Race* _____ **Youth's Ethnicity*** _____

Youth's Current Address* _____
Street Address

_____
City *State* *Zip code*

_____
Facility Address if applicable. Leave this blank for a residence.

Is Youth a Maryland Resident?* ◯ Yes ◯ No ◯ Unsure

What is Youth's County of Residence?* _____

What is 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 (ies), list Agency (ies):

Is the Youth currently eligible for Medical Assistance?* ◯ Yes ◯ No ◯ Unsure

If the youth is currently receiving Medical Assistance, enter the MA number : _____

Is the youth currently enrolled in school?* ◯ Yes ◯ No ◯ Unsure

Current grade if enrolled* _____

Has school been notified of LCT meeting?* ◯ Yes ◯ No ◯ Unsure

If currently enrolled in school:

_____
School Name

_____
School City *School State* *County/Jurisdiction*

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Educational Goal (or state date if completed):

- ◯ Diploma _____
- ◯ GED _____
- ◯ Certificate of Completion _____
- ◯ Other _____

Date last 504 Plan completed _____

Date Last IEP Completed _____

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
- ☐ 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)

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

_____
School Name

_____
School City *School State*

Withdrawal or Graduation Date and Grade: _____

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What are PARENT(S) expected outcome of meeting?* _____

Have parental rights been terminated?

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

If parental rights have been terminated, list names of those parents below:

Name of Legal Guardian #1*:

_____

Prefix *First Name* *Middle Name* *Last Name* *Suffix*

Relationship to child/youth _____

Address of Legal Guardian #1 _____

Street Address

_____

City *State* *Zip* *County of Residence*

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

_____

City *State* *Zip* *County of Residence*

Email _____

example@example.com

Phone Number of Legal Guardian #2 _____

Please enter a valid phone number

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Any parental history of substance/alcohol and/or incarceration? Yes ☐ No ☐ If yes, please explain:

Are there other siblings in the home? If yes, please list below:

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Justice/Safety Considerations Regarding Child/ Youth:

Has the youth ever witnessed or experienced gun violence?	◯ Yes	◯ No
Has the youth been suspended out of school for violent offenses or weapon possessions?	◯ Yes	◯ No
Has the youth experienced multiple suspensions, expulsions or health-related exclusions?	◯ Yes	◯ No
Has the youth been convicted of a misdemeanor? If so, how many?	◯ Yes	◯ No
Have any of the parents/guardians been justice involved?	◯ Yes	◯ No
Has the youth been a victim of human trafficking? If so, is the youth connected to services?	◯ Yes	◯ No
Has the youth been a victim of cyberbullying?	◯ Yes	◯ No

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Health Considerations Regarding the Child/Youth:

Has the youth visited the hospital more than once in the last year for behavioral health concerns? ◯ Yes ◯ No ◯ N/a

If yes, how many times visited?

Has the youth visited the emergency room more than once in the last year for behavioral health concerns? ◯ Yes ◯ No ◯ N/a

If yes, how many times visited?

Has the youth had one or more than one Mobile Crisis interactions in the last year? ◯ Yes ◯ No ◯ N/a

If yes, how many times?

Has the youth experienced one or more hospitals overstays? ◯ Yes ◯ No ◯ N/a

If so, how many times?

Does the youth have an emotional, intellectual and/or developmental disability that might cause the youth to present a threat to themselves or others? ◯ Yes ◯ No

Does the youth have behavioral, intellectual, emotional, and/or developmental disabilities that impact their quality of life and require support beyond what the guardian can provide? ◯ Yes ◯ No

Does the youth have medical conditions in addition to emotional, intellectual and developmental disabilities? ◯ Yes ◯ No

Is the youth considered high risk for substance use disorders based on the CRAFFT screening tool? ◯ Yes ◯ No

Has the youth attempted community-based behavioral health supports in the past without success? ◯ Yes ◯ No

If so, what providers and how many times?

Has the youth utilized 911/988/behavioral health crisis services before? ◯ Yes ◯ No

If so, how many times?

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Additional Information Regarding the Child/Youth:	Yes, Currently	No, but Prior	Never	N/A
Diagnosis of Autism	☐	☐	☐	☐
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	☐	☐	☐	☐

Provide an overview of the youth's strengths:*

Describe present issues/reason you are seeking services:*

Provide an overview of the youth's clinical needs:*

List current diagnosis and current medications:*

Services received from/agency involvement with:

	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 services received, past and present. Use the name of the agency listed above or private provider and dates of service:

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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 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 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 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:

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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* *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? _____

Other information: