HARFORD COUNTY LOCAL CARE TEAM (LCT) REFERRAL

Referral Received _____

LCT Scheduled _____

Name of Child: _____
Last Name *First Name* *Middle*

Address: _____
Street *Town* *State/Zip Code*

Gender: _____ Race: _____ Ethnicity: _____ Religion: _____ Birth Date: _____

Parent/Guardian Name(s) _____

Parent/Guardian Phone: Home: _____ Work: _____ Cell: _____

Parent/Guardian Email _____

Parent/Guardian Address: _____
Street *Town* *State/Zip Code*

Child's Primary Medical Insurance: _____

Child's Secondary Medical Insurance: _____

Referring Agency/Person: _____ Phone: _____

1. Describe why you are seeking services:

2. When did the problem begin?

3. Is there involvement with:

Division of Rehabilitation Services?	Yes ☐	No ☐	*Probation* ☐
Department of Social Services?	Yes ☐	No ☐	
Department of Juvenile Justice?	Yes ☐	No ☐	
Developmental Disabilities Administration	Yes ☐	No ☐	*Intake* ☐
Family Navigator	Yes ☐	No ☐	

If yes, Worker's Name(s): _____ Phone: _____

Reason for Services: _____

4. Name of School: _____ Grade: _____

Has the child received any Special Education Services? Yes ☐ No ☐ If yes *504 Plan* ☐ *IEP* ☐

If yes, what services? _____

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5. Child's Current Treating Mental Health and/or Substance Abuse Provider(s):

   Provider Name: _____ Phone: _____

   Provider Name: _____ Phone: _____

6. Child's Current Medical Diagnoses: _____

   Mental Health Diagnoses: _____

7. Is the child currently prescribed any medication? Yes ☐ No ☐

   If yes, please list medication(s):

   Is the child currently compliant with his/her medication(s)? Yes ☐ No ☐

8. Has the child ever received counseling or outpatient treatment in the past? Yes ☐ No ☐

   If yes, when and where? _____

   Number of years of active mental health treatment _____

9. Has the child ever received residential treatment before? Yes ☐ No ☐

   If yes, when and where? _____

10. Has the child ever had a psychiatric hospitalization before? Yes ☐ No ☐

    If yes, when and where? _____

    Number of ER visits or other Crisis Episodes in the last 12 months: _____

11. Has the child ever planned for/tried to commit suicide? Yes ☐ No ☐

    If yes, when? _____

12. Has the child ever lived with a non-parent? Yes ☐ No ☐

    If yes, when and with whom? _____

13. Is the child adopted? Yes ☐ No ☐

    If yes, at what age? _____

14. Is drug or alcohol abuse suspected currently? Yes ☐ No ☐

    If yes, please explain. _____

    Current or prior addiction or substance abuse treatment: _____

15. Dates of Previous LCT or Local Coordinating Council Meeting(s): _____

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16. List Members of child's current household

Name	Age	Relationship to Child

17. Check any entitlements the child currently receives:

☐ *SSI/SSDI* ☐ *Food Stamps (Family)* ☐ *Survivor's Benefits* ☐ *Other:*_____

18. Please list the name, address and fax of others you would like to invited to the LCT meeting. Only list parties for whom the sponsoring LCT Agency has written consent from the parent/guardian to invite:

Name	Mailing Address	Fax

19. Completed by: _____ Relationship: _____ Date: _____

20. LCT Representative Signature _____ Agency: _____ Date: _____

A Local Care Team meeting cannot be scheduled without the signature of the sponsoring agency's LCT representative which confirms that there is a need for a review by the LCT and that the LCT representative has reviewed this Referral.

Once completed, please mail, fax or email this Referral to:
Local Care Team (LCT)
Harford County Local Management Board
125 N. Main Street
Bel Air, MD 21014
Fax 410-803-0433 or email llrajala@harfordcountymd.gov | Attn: Laurie Rajala

For questions related to the LCT or this Referral form, please call your agency's LCT Representation

Please NOTE: It is the responsibility of the LCT Representative to ensure that the following are brought to the scheduled LCT meeting: 10 copies of the LCT Referral Form and any other information which will be important for the LCT to review, i.e. recent psychological or educational reports, IEP or 504 Plans, recent discharge summaries, letters of recommendation, recent service or treatment plans, etc.

Appropriate releases of information to the LCT as well as a 10-day Waiver, if needed, are also required to be held in the LCT case file; please bring one copy.