HARFORD COUNTY LOCAL CARE TEAM (LCT) AND INTERAGENCY PLACEMENT COMMITTEE (IPC) REFERRAL FORM

Effective June 1, 2022

Instructions

- Please complete the form to make a referral to the Local Care Team.
- 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 referral to the Local Care Team, complete the form and send it to the Local Care Team coordinator. Access the Local Care Team Directory **here**. In Harford County, contact: **Laurie Rajala, LCT Coordinator, 410-638-3389 or llrajala@harfordcountymd.gov.**

Name of Youth:*

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

Youth's Date of Birth:* _____ **Youth's Gender:*** _____
Month/Day/Year

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

Language primarily spoken at home* _____

Youth's Current Address:* _____
Street *City* *State* *Zip Code*

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

_____
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/Agencies, list Agency or Agencies:

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

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

_____

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

Current grade if enrolled:* _____

If currently enrolled in school:

_____
School Name

_____
School City *School State*

Jurisdiction of school where the youth is enrolled: _____

Educational Goal:

◯ Diploma

◯ GED

◯ Certificate of Completion

◯ Other _____

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)

Date last 504 Plan completed: _____

What is the youth's resident school system? _____

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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: _____

Have parental rights been terminated?

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

If parental rights have been terminated, list the name of the parent(s) whose rights 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

_____
City *State* *Zip*

County of address of Legal Guardian #1 _____

Legal Guardian #1 Email _____
example@example.com

Phone Number of Legal Guardian #1 _____
Please enter a valid phone number.

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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 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:

	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	○	○	○	○

Provide current diagnosis*:

Provide an overview of the youth's strengths*:

Describe why you are seeking services*:

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

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

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 ○

If yes, what is the level of care recommended?*

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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 -** 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*

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What is the Expected Date of Placement? _____

What is the Expected Date of Discharge if youth is currently placed? _____

Other information:

Please list members of child's current household:

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Please list the names, email and telephone numbers of others you would like invited to the LCT meeting. Only list parties for whom the sponsoring LCT Agency has written consent from the parent/guardian to invite:

Name _____ Email Address _____

Phone Number _____ Agency _____

Name _____ Email Address _____

Phone Number _____ Agency _____

Name _____ Email Address _____

Phone Number _____ Agency _____

Name _____ Email Address _____

Phone Number _____ Agency _____

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Name of person completing form*

_____ _____

First Name *Last Name*

Are You*

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

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.

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