KENT COUNTY LOCAL CARE TEAM REFERRAL

Referral Received:

LCT Scheduled:

Name of Child			
Please Print (Last)	(First)	(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 Address:

Child's Medical Insurance	(primary)
Child's Medical Insurance	(secondary)
Referring Agency or Person	Telephone:

1. Describe why you are seeking services:

2. When did the problem begin?

3. Is there any involvement with:

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

Probation ☐ *Intake* ☐

If yes, Worker's Name(s)	Telephone:

Reason for Services:

4.Name of School:	Grade:

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

If yes, what services?

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

6. Child's Current Medical Diagnoses

Mental Health Diagnoses

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

If so, please list:

Is the child currently compliant with his/her medications? 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 E. R. visits or other Crisis Episodes 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 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 Local Care Team or Local Coordinating Council Meeting(s): _____

16. List members of child's current household.

Name	Age	Relationship to Patient

17. Check any entitlements the child currently receives

☐ SSI/SSDI ☐ Food Stamps (Family) ☐ Survivor's Benefits ☐ Other_____

18. Please list name and address/FAX 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	Mailing Address or FAX Number

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 Local Care Team and that the LCT representative has reviewed this Referral.)

When completed, please email, mail or FAX this Referral to:

Local Care Team
C/O Kent County Local Management Board
400 High Street
Chestertown MD 21620
Attn: Rachael Carmody
rcarmody@kentgov.org
Fax: 410-810-2674

For questions related to the Local Care Team or this Referral form, please call your agency's LCT representative.

Please note:

It is the responsibility of the Local Care Team Representative to ensure that the following are brought to the scheduled LCT meeting: copies of the LCT Referral Form and of any information which will be important for the Local Care Team to review (e.g. 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.

Kent 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; the Alcohol and Drug Abuse Administration; the Behavioral Health Administration or the local Core Service Agency; the local School System; the local Health Department; the local Department of Social Services; and the Local Management Board; and the Division of Rehabilitation Services.

The information may include, but is not limited to: (Please check those applicable)

☐ 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
☐ urinalysis results.

Please specify limitations to the exchange and release of information:

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

☐ Assistance with identification of individual needs and potential resources to meet identified needs for a family with an intensive needs child
☐ Interagency discussion and problem solving for individual child and family needs and systemic 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 Kent County Local Management Board
400 High Street Chestertown MD 21620
(410) 810-2673 Fax: (410) 410-810-2674