

# 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](mailto: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.

**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 \***

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**

**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

- 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**

**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**

## 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:

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



**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? \***

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.**

**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

**Preceding Prior Placement**

Facility Name

Street Address

City State

**Preceding Prior Placement**

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:**