**Garrett County LCT Referral Form**

|  |  |  |  |
| --- | --- | --- | --- |
| Referral Date: |  | LCT Meeting Date: |  |
| Referring Agency:  |  | Case Worker:  |  |
| Phone: |  | Email: |  |
| Purpose of Meeting:  | New Case | Review | Emergency | VPA |  |  |  |

**Section 1. - personal information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name of Child: |  |  |  | Gender:  | Male [ ]  Female [ ]  |
| D.O.B. |  | Age: |  | Race: |  |  |  |
|  |  |
| **Child’s Current Living Situation: (check one)** |
| Parents | Foster Care | Relative  | Group Home | Hospital | Detainment | Independent Living: | Other (please list): |
| Child’s Current Residence (Facility’s Name): |  |
| Address:City:State/Zip Code: |            |
| **Mother/Caregiver Name**: |  | Birth [ ]  | Adoptive [ ]  | Step [ ]  | Other [ ]  (Explain): |
| Address:City:State/Zip: |  | Address Type: | Permanent [ ]  Temporary [ ]  |
| Phone Number (home): |  | Phone Number (work): |  |
| Occupation: |  | Date of Birth: |  |
| **Father/Caregiver Name**: |  | Birth [ ]  | Adoptive [ ]   | Step [ ]  | Other [ ]  (Explain): |
| Address:City:State/Zip: |                 | Address Type: | Permanent [ ]  Temporary [ ]  |
| Phone Number (home): |       | Phone Number (work): |       |
|  |
| **GUARDIAN** (if other than parent): |
| Name of person or agency: |  | Address:City:State/Zip: |  |
| Relationship: |  |
| Phone (home): |  | Phone (work): |  |
| Occupation: |  | Date of Birth: |  |

**Section 2. - agency information/legal status**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Is child court involved?  | Yes [ ]  No [ ]  | Court Committed? | Yes [ ]  No [ ]   | Commitment Type: |  |
| Lead Agency: |  | Case Manager: |  |
| Address: City:State/Zip Code: |  | Email: Phone: |  |
| Co-Lead Agency: |  | Case Manager: |  |
| Address: City:State/Zip Code: |  | Email: Phone: |            |
| Funding Agency: | DJS [ ]  | DSS [ ]  |  LMB [ ]  | CSA [ ]  | Medical Assistance [ ]  | LEA [ ]  (List Jurisdiction):      |
| If applicable, list Co-Funding Agency/Agencies: |  |
| Child’s Attorney (If Applicable): |  | Phone: |  |
| Address:City:State/Zip Code: |  |

**Section 3. - health/medical information**

|  |  |  |  |
| --- | --- | --- | --- |
| Medical Assistance  | Yes [ ]  No [ ]  | Applied for Medical Assistance but not enrolled: |  Yes [ ]  No [ ]  |
|  |  |
| Currently Receiving SSI: | Yes [ ]  No [ ]  | Private Insurance  | Yes [ ]  No [ ]  |
|  |  |
|  |  |
| **CURRENT DSM DIAGNOSIS:**  |  |
| Axis I: |  |
| Axis II: |  |
| Axis III: |  |
| Axis IV: |  |
| Axis V: Current GAF |  | Highest Past Year  |  |

**Section 4. - educational information**

|  |  |  |
| --- | --- | --- |
| Current school placement: |  | Private [ ]  Public [ ]  |
| Special Education? | Yes [ ]  No [ ]  | Most Recent IEP Date: |  | Grade:  |  |
| Current Educational Service(s): |  |
| Is DDA application appropriate? | Yes [ ]  No [ ]  | Application Date: |       | Application Status: |       |

**Section 5. - background**

|  |  |
| --- | --- |
| 1.) History of Clinical Services: |  |
| 2.) Out of home placements (name, date, disposition): |  |
| 3.) What services have been provided: (i.e. case management, respite, group home, etc.) |  |
| 4) Other pertinent background information:  |  |

|  |  |
| --- | --- |
| Who to invite to a LCT meeting or Emergency LCT meeting: | [ ]  Parent(s) [ ]  Attorney (of child and/or parent(s) [ ]  Therapist  |