Garrett County Local Care Team

This Garrett County Local Care Team Referral form is to be completed by an agency representative/referral source or by a self (or family) referral.

IMPORTANT: Please inform the parent/guardian that you are making this referral on their behalf and provide the parent/guardian with information about the Local Care Team.

For assistance completing this referral or for questions, please call 301-334-7440 or 301-334-7445.

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* Indicates required question

Youth's Name (First and Last) *

Date of Birth for Referred Youth: *

Youth's Gender *

Mark only one oval.

- Male
- Female
- Transgender Male
- Transgender Female
- Gender Queer
- Prefer not to answer

Youth's Race: *

Mark only one oval.

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Pacific Islander
- White
- Multi-Racial
- Other Race
- Prefer not to answer

Youth's Ethnicity: *

Mark only one oval.

- Hispanic, Latinx, or Spanish Origin
- Not Hispanic, Latinx, or Spanish Origin
- Prefer not to answer

Full Name of Parent(s)/Legal Guardian(s) *

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Parent(s)/Guardian(s) Email(s):

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Parent(s)/Guardian(s) Phone Number(s): *

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Parent(s)/Guardian(s) Street Address:

Referred Youth's Current School:

If the referred youth is **NOT** currently enrolled in school, please provide:
The name of the last school the youth attended, the youth's withdrawal date, and the grade last attended

If the referred youth has an Individualized Education Plan (IEP), please provide the date of last IEP

If the referred youth has a 504 Plan, please provide the date of last 504 Plan

Please check any of the following that apply to the referred youth: *

Check all that apply.

- Diagnosed with more than one mental health diagnosis
- Diagnosed with a developmental disability
- Exhibited aggressive behaviors, current or previous (behaviors that violate social boundaries and/or cause or threaten to cause physical or emotional harm to others. Examples include verbal and physical abuse and harming personal property)
- Exhibited sexually reactive behavior (defined as abusive or aggressive behaviors outside of the range of normal sexual development. Examples include sexual gestures, sexualized talk, exposing oneself, public masturbation, stealing intimate items, and voyeurism)
- Reported suicidal ideation (thinking about, considering, or planning suicide)
- Previous suicide attempt
- Exhibited or engaged in fire setting behavior
- Has a substance use history
- Has a human trafficking history
- Is pregnant or parenting a child
- Has been identified as needing a community-based service that is not available in the jurisdiction
- Has been clinically recommended for Residential Treatment Center (RTC) but denied placement NOT due to bed availability (e.g. aggression, age, IQ, sexualized behavior, etc.)
- None of the above apply to the referred youth

Please identify any present/recent/relevant out-of-home placements for the referred youth, including the name of the facility and date(s) of placement. *

Please identify any current supports that the child/youth/family is involved in (therapy, in-home services, PRP, etc.) *

Please select any of the below characteristics that relate to the Local Care Team referral for the identified child/youth: *

Check all that apply.

- Child/youth is currently in or at risk of an extended hospital stay
- Child/youth is at risk of ejection from a community placement or higher level of care (Residential Treatment Center, Diagnostic Center, Therapeutic Group Home, etc.)
- Child/youth is not formally involved with an agency and is at risk of a community/RTC/psychiatric/out-of-state placement or treatment access. The child/youth has intensive needs and are in need of placement/treatment access in a higher level of care though a coordinated effort or plan has not yet begun
- Child/youth's needs cannot be addressed by one agency. The youth is multi-system involved.
- Child/youth is being referred by hospital personnel in accordance with the Universal Hospital Discharge Planning Protocol
- Child/youth is being referred by self or by family
- None of the above relate to the referred child/youth.

Full name of the individual completing this referral: *

Phone number of the individual completing this referral: *

Name of the agency/organization you represent OR your relationship to the referred youth: *

Signature: *

Today's Date: *

IMPORTANT
If the child or youth has been recommended for a Residential Treatment Center (RTC), is being discharged from the RTC, or the parent(s)/guardian(s) have requested a Voluntary Placement Agreement (VPA), please proceed to the next page and answer all questions in Section 2 before submitting this Referral Form.

If the youth has **NOT** been recommended for RTC/been placed in RTC or the parent(s)/guardian(s) have not requested a VPA, please proceed to the next page, scroll to the bottom, and click on "Submit."

If you have any questions or concerns or need assistance completing this section, please contact Fred Polce or Lindsay Broadwater at 301-334-7440 or 301-334-7445.

Residential Treatment Center (RTC) or Voluntary Placement Agreement (VPA)

Please continue to answer the questions in Section 2 if the referred child or youth has been recommended for a Residential Treatment Center (RTC), RTC discharge planning is needed, or the parent(s)/guardian(s) have requested a Voluntary Placement Agreement (VPA)

Has the child/youth's parent(s)/guardian(s) requested a Voluntary Placement Agreement (VPA)?

Mark only one oval.

- Yes
- No
- Unsure

If there has been a clinical recommendation for a Residential Treatment Center (RTC), please indicate the date that the recommendation was received:

Briefly describe the reason(s) that RTC placement has been recommended:

What is the expected date of RTC placement, if this has been identified?

If the child/youth is currently placed, please indicate the expected date of discharge if identified:

If the child/youth is being discharged from placement, please identify what services are anticipated to be needed after the placement:

Signature:

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