Howard County Local Care Team
Steps to Make a Referral for a Local Care Team Meeting

The Howard County Local Care Team (LCT) is an interagency council designed to provide resources and support to families who need to access services for a child with intensive emotional and behavioral needs. This collaborative effort brings together representatives of several agencies to review a child's specific needs. They work together with the family to identify programs and services that best serve the child. The primary goal of the LCT and its family-focused partners is to help families receive the support and services they need to ensure children remain in their homes and communities.

The Local Care Team convenes on the 2nd and 4th Wednesday of each month at the Howard County Community Resources Campus located at 9830 Patuxent Woods Drive, Columbia, MD 21046.

Families can participate in the Local Care Team if they:

- Live in Howard County.
- Are struggling with multiple areas of need.
- Willing to participate in the process and communicate their intent to follow through with recommendations with support from the referring agency.

To refer a family or to self-refer to the Local Care Team:

1) **Contact the Local Care Team Coordinator,** Candace Ball at 410-313-6552 or e-mail at cmball@howardcountymd.gov
2) **Prepare the packet.** Complete the Local Care Team Referral. Please be sure to complete all sections to ensure that all of the family's needs are presented to the Team. Include any supplemental packet information relevant to the case (educational reports/IEP information; up-to-date psychological/psychiatric evaluations; court orders; hospital discharge summaries; medical reports/recommendations for treatment; etc.)

Mail, Fax, or e-mail this Referral to:

Howard County Local Care Team
9830 Patuxent Woods Drive
Columbia, Maryland 21046
FAX 410-313-6424
cmball@howardcountymd.gov
Attn: Candace Ball

NOTE: The entire packet, including signed consent forms, must be submitted by 5:00 PM, **the Wednesday** prior to the scheduled meeting.

HOWARD COUNTY LOCAL CARE TEAM REFERRAL

Referral Received: _____
LCT Scheduled: _____

Child Name*:* _____

Referral Source: _____Telephone:_____

Family Demographics

Please list referred child first, followed by all other children and adults in the home.
*** Indicate whether Biological Parent, Stepparent, Partner, Guardian, Sibling, or Other Relative (specify)**

Name	Relation*	DOB	Age	Gender	Race	School & Grade (if applicable)

Purpose of Meeting

Describe why you are seeking services, including when the problem or concerns began. What questions are you hoping to have answered at the meeting? Additional space provided in the back of the packet.

_____

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Child's Address: _____
(Street) (City) (State) (Zip Code)

Parent/Guardian Phone: Home: _____Work: _____ Cell: _____

E-mail:_____

Parent/Guardian Address: _____
(if different than above)
Parent/Guardian Address: _____
(if different than above)

Has the child ever lived with a non-parent? ☐ No ☐ Yes If yes, when and with whom?_____

_____

Is child adopted? ☐ No ☐ Yes If yes, at what age?_____ ☐ Domestic ☐ International

Child's Medical Insurance (primary) _____secondary) _____

Identified Child's History

School Background

Name of School: _____ Grade: _____

a. History of educational services:
   ☐ **No** ☐ **Yes, Specify:** *504 Plan* ☐ *IEP* ☐
b. Retentions (repeated grade/held back):
   ☐ **No** ☐ **Yes, Specify:**
c. Suspensions:
   ☐ **No** ☐ **Yes, Specify:**
d. Attendance problems:
   ☐ **No** ☐ **Yes, Specify:**

e. Academic strengths:

f. Academic difficulties:

g. Current academic performance:

Community Information

h. Activities/Interests (e.g., extracurricular activities; hobbies/interests):

i. Employment (past & present):

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

_____

_____

a. Medical Health: ☐ **Prior** ☐ **Current** ☐ **In Treatment?**
Specify:
b. Mental Health: ☐ **Prior** ☐ **Current** ☐ **In Treatment?**
Specify:
c. Substance Use: ☐ **Prior** ☐ **Current** ☐ **In Treatment?**
Specify:
d. Developmental Disability: ☐ **Prior** ☐ **Current** ☐ **In Treatment?**
Specify:

3. Child's Current Diagnoses_____
a) Is the child currently prescribed any medications? ☐ No ☐ Yes

If so, please list: _____

b) Is the child currently taking their medications as prescribed? ☐No ☐ Yes

4. Has the child ever received residential mental health treatment? ☐ No ☐ Yes

If yes, when and where? _____

5. Has the child ever had a psychiatric hospitalization (emergency petition)? ☐ No ☐ Yes

If yes, when and where? _____

6. Number of Emergency Department (ER) visits related to crisis or other crisis episodes last 12 months (calls to 911 or mobile crisis) _____

Has the child ever been hospitalized for thoughts of suicide or attempt of suicide? ☐ No ☐ Yes

Has the child ever been hospitalized for thoughts of homicide or harming others? ☐ No ☐ Yes

If yes, when? _____

7. **What strengths does the family have? (ex. Support system, employment, insight into child's behaviors, etc.)**

_____

_____

_____

_____

_____.

8. **What other supports does the child/family need? (ex. Housing instability, family mental health support, financial concerns, etc.)**

_____

_____

_____

_____

_____.

Check any benefits the child currently receives:

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

Dates of Previous Local Care Team or Local Coordinating Council Meeting(s): _____

Agency Involvement

Please include past and present agencies involved with the child(ren) or family. If the agency is currently involved, include the name of the worker(s) and contact information if a release is on file:

Agency	Prior (N/Y)	Current (N/Y)	Case Worker Name/Contact (If current involvement)
Social Services- Family Pres./CPS/Foster Care			
Social Services- Financial (i.e., TCA, Food Stamps)			
Health Department- Bureau of Behavioral Health			
Department of Juvenile Services (DJS)			
DDA Involvement:			
Other:			

Is the child or family involved in any waiver programs (i.e., Autism Waiver)? ☐ Yes ☐ No

If yes, please specify: _____

Persons to Invite to the Meeting

Please list names, relationship to child(ren), and contact information including phone numbers and email addresses, if applicable.

Name	Relationship	Phone & Email

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 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.)

Once completed referral is screened by the Sponsoring LCT Representative, the Sponsoring LCT Representative may mail, fax or email this referral to:

Howard County Local Care Team
9830 Patuxent Woods Drive
Columbia, Maryland 21046
FAX 410-313-6424
cmball@howardcountymd.gov
Attn: Candace Ball

For questions related to the Local Care Team or this Referral form, please call Ms. Ball at 410-313-6552.

Please use this space to continue writing the "Purpose of Meeting" section, if needed.

Howard County Local Care Team

Authorization For Interagency Release of Information/Records

Parent(s)/Guardian(s) Name: _____ DOB: _____

Child or Children's Name(s): _____ DOB: _____
_____ DOB: _____
_____ DOB: _____
_____ DOB: _____
_____ DOB: _____
_____ DOB: _____

I (We) give my (our) permission for my (our) family to be referred to the Howard County Local Care Team (LCT). I (we) understand that the Local Care Team is comprised of various state/county/local agencies and organizations concerned primarily with the provision of services to children and families. Members include:

- Howard County Health Department- Bureau of Behavioral Health
- Howard County Local Management Board
- Howard County Public School System (HCPSS)
- Department of Juvenile Services (DJS)
- Department of Social Services (DSS)
- Developmental Disabilities Administration (DDA)
- Division of Rehabilitation Services (DORS)
- Parent Advocate
- Other Agencies/Organizations who may help with the family's action plan:

_____ _____
_____ _____

I (We) understand that this form authorizes appropriate partnership between family members and Local Care Team members during which family information will be exchanged and released. I (We) understand that information obtained will be used to plan for the delivery of appropriate services for my (our) family and for program evaluation. The information to be obtained may include records pertaining to:

☐ Medical History
☐ Developmental History
☐ Psychological Evaluations
☐ Treatment Plans
☐ Psychiatric Diagnoses & Reports
☐ Other:
☐ Discharge Summary
☐ Medication Administration Records
☐ Dept. of Juvenile Services Information
☐ Educational Information
☐ Social Services Information
☐ ALL OF THE ABOVE

I (We) understand that authorizing this disclosure of information is voluntary. I (We) understand that I (we) have a right to revoke this authorization at any time. I (We) understand that the revocation will not apply to information that has already been released in response to this authorization. I (We) understand that if I (we) revoke this authorization that I (we) must do so in writing and present my written revocation to the Howard County Local Care Team. This consent will expire two (2) years from the date signed unless otherwise specified in the space that follows: _____

I (We) understand that Maryland is a mandatory child abuse/neglect reporting state and that child service providers, among others, are required to report if child abuse or neglect is evident or suspected (Family Law § 5-704).

_____ _____
Signature (Parent or Legal Guardian) Signature (Witness)

_____ _____
Print Name (Parent or Legal Guardian) Print Name (Witness)

LCT 10 Day Waiver

**** Please complete a parent or legal guardian AND attorney waiver if you'd like to expedite a case review****

Child		**DOB**	
Jurisdiction		**Lead Agency**	

The Local Care Team (LCT) is a forum for interagency discussion and problem solving for individual child and family needs and systematic needs. Although the LCT does not make residential placement decisions nor is the LCT approval required for residential placements, in the course of the interagency discussions, an Out of State residential placement may be explored, resulting in the LCT making a recommendation to the Lead Agency that a residential placement be considered.

In accordance with Maryland law (Maryland Human Services Article, Section 8-409), parents and attorneys are entitled to written notification at least 10 (ten) days prior to any meeting of the LCT in which their child/client's out of State placement is discussed.

If you waive the right to a full ten (10) day notice (by signing below), the review of your child/clients case may be expedited. **You must provide a working phone number for your case to be expedited, so that you may be notified of the meeting.** In any event, you will be notified in writing of any decisions of the LCT concerning your child's placement.

This form is optional. If you do not sign this form, your child/client's case will be reviewed by the LCT after providing (10) ten days written notice to you.

I wish to be notified in advance of the date of the Local Care Team meeting to discuss my child/client. I have had the opportunity to review and discuss this form with my child/client's case manager, I do *not* need ten (10) days written notice for the (please check the appropriate box below):

Print name (parent/guardian/attorney)	
****** Please complete a parent or legal guardian AND attorney waiver if you'd like to expedite a case review******	
I am the child's	☐ Parent ☐ legal guardian ☐ attorney
Phone Numbers	Home Work Other

This waiver will expire 1 year from the date of the parent/guardian/attorney signature. This waiver may be rescinded prior to the expiration date by submitting a written letter to the Lead Agency of the intent to withdraw this waiver. The date of the Lead Agency's receipt of this letter will be the effective date of the termination of this waiver; the Lead Agency is responsible for notifying the LCT in writing of any waivers withdrawn for the LCT.

_____

Parent/Guardian/Attorney Signature **Date**

_____

Lead Agency Verification:

_____

Lead Agency Worker-Print Name ***Signature*** ***Date***

Effective 7/2015

Howard Local Care Team Members

Member Agency	Representative	Contact Information
Howard County Local Children's Board	Marsha Dawson	410-313-5929 mdawson@howardcountymd.gov
Howard County Public Schools	Kathy Stump	410-313-5359 kathy stump@hcpss.org
Howard County Public Schools Office of Student Services	Shereima Smith	410-313-6838 shereima_smith@hcpss.org
Howard County Health Department- Bureau of Behavioral Health	Kenyatta Cully	410-313-7378 kcully@howardcountymd.gov
Howard County Youth Services/Diversion	Katie Turner	410-313-2618 kturner@howardcountymd.gov
Department of Juvenile Services	Timothy Madden Deidre Steed-Bonse	410-480-7873 Timothy.Madden@maryland.gov 410-527- 4312 deidre.steed@maryland.gov
Department of Social Services	Kathleen Jackson Michael Demidenko Stephanie Caruso	410-872-8808 kathleen.jackson@maryland.gov 410-872-8264 mike.demidenko@maryland.gov 410-872-8762 stephanie.caruso@maryland.gov
Developmental Disabilities Administration	Debra Kroneberger	410-234-8253 debra.kroneberger@maryland.gov
Division of Rehabilitation Services	Jacqueline Myers	410-290-2641 jacqueline.myers@maryland.gov
Maryland Coalition of Families (MCF)- Parent Advocate	Cindy Kirk	443-878-3116 ckirk@mdcoalition.org
Center for Children	Tasha Walls	240-320-2023 walls@center-for-children.org
Local Care Team Coordinator	Candace Ball	410-313-6552 cmball@howarcountymd.gov