

Baltimore City Local Care Team Request for Local Care Team (LCT) Meeting

Youth's First Name:		Youth's Last Name:	
Date of Birth:		SSN:	
Identified Gender:		Race:	
Address:			
State:	MD	ZIP Code:	
Phone:			

Parent/Guardian: Address: Phone:	
Parent/Guardian: Address: Phone:	
Other: Address: Phone:	

Person requesting meeting: Relationship to youth: Contact Information:	Do you have the individual's (ages 18-21) or family's permission to discuss this youth?
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Please list those other individuals, including contact information, whom you would like to be invited to the LCT meeting (including the youth's lawyer for DJS):

Does the youth receive Medical Assistance?	Does the youth receive SSI?
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Current school & grade:																											
Please list any medical conditions:	<table border="0"> <tr> <td><input type="checkbox"/> Allergy</td> <td><input type="checkbox"/> High Blood Pressure</td> </tr> <tr> <td><input type="checkbox"/> Anemia</td> <td><input type="checkbox"/> High Cholesterol</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Immune Disorder</td> </tr> <tr> <td><input type="checkbox"/> Birth Defects</td> <td><input type="checkbox"/> Kidney Disorder</td> </tr> <tr> <td><input type="checkbox"/> Bleeding Problems</td> <td><input type="checkbox"/> Lead Poisoning</td> </tr> <tr> <td><input type="checkbox"/> Cerebral Palsy</td> <td><input type="checkbox"/> Seizures</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Speech Disorder</td> </tr> <tr> <td><input type="checkbox"/> Ear Infections</td> <td><input type="checkbox"/> Sexually Transmitted Infection (STI)</td> </tr> <tr> <td><input type="checkbox"/> Food Allergy</td> <td><input type="checkbox"/> Thyroid Disorder</td> </tr> <tr> <td><input type="checkbox"/> Genetic Disorder</td> <td><input type="checkbox"/> Vision Problems</td> </tr> <tr> <td><input type="checkbox"/> Head Injuries</td> <td><input type="checkbox"/> Other:</td> </tr> <tr> <td><input type="checkbox"/> Headaches</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Hearing Problems</td> <td></td> </tr> </table>	<input type="checkbox"/> Allergy	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Anemia	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Asthma	<input type="checkbox"/> Immune Disorder	<input type="checkbox"/> Birth Defects	<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> Bleeding Problems	<input type="checkbox"/> Lead Poisoning	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Seizures	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Speech Disorder	<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Sexually Transmitted Infection (STI)	<input type="checkbox"/> Food Allergy	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Genetic Disorder	<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Head Injuries	<input type="checkbox"/> Other:	<input type="checkbox"/> Headaches		<input type="checkbox"/> Hearing Problems	
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Please list any behavioral challenges:	<ul style="list-style-type: none"> <input type="checkbox"/> Has challenges with effective communication, has difficulty reasoning or listening to another persons perspective <input type="checkbox"/> Does not find activities interesting that were previously enjoyable <input type="checkbox"/> Gets into physical fights with peers or family members <input type="checkbox"/> Has challenges being honest and truthful or takes possession of itmes that may not belong to him/her/them <input type="checkbox"/> Has a difficult time creating and building relationships with adults <input type="checkbox"/> Has participated in self-harm (e.g., cutting or scratching self, attempted suicide) <input type="checkbox"/> Appears sad or unhappy <input type="checkbox"/> Has challenges building trusting relationships with friends, family or adults <input type="checkbox"/> Finds home to be unsafe and/or has threatened to or has run away from home <input type="checkbox"/> Finds it difficult to follow rules, laws or expectations <input type="checkbox"/> Engages in inappropriate sexual behavior (e.g., sexually active, exhibits self, sexual abuse toward family members or others) <input type="checkbox"/> Becomes irritatble easily 																										

<p>Please list any behavioral challenges (cont'd):</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Has difficulty concentrating, thinking clearly, or attending to tasks <input type="checkbox"/> Seems to engage others negatively when distracted or bored <input type="checkbox"/> Can be demanding when needs are not met <input type="checkbox"/> Experiences nightmares, difficulty with sleeping, oversleeping or waking up from sleep too early <input type="checkbox"/> Can feel overly anxious or nervous <input type="checkbox"/> Has friends of whom I don't approve <input type="checkbox"/> Has difficulty making and keeping friends <input type="checkbox"/> Has difficulty waiting his/her/their turn in activities or conversations <input type="checkbox"/> Is triggered easily enough to be considered a threat to others or self
<p>Please list any substance use</p>	
<p>Please list what services or agencies he/she/they has/have been involved with up to now</p>	

<p>Meeting Purpose</p>	
<p>Please explain why you are requesting an LCT meeting:</p>	

Please list your youth's strengths & interests:

Do you consent to this meeting being presented on your behalf by the lead agency (DJS/DSS) in the event of your absence? (LCT Coordinator will follow up with family following LCT Meeting) Y/N

Please note: If parent/guardian is not the person completing the form, please verify that the above statement was communicated with them.

Please attach any supplemental 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.) Once packet is complete, please fax to Moriah Smalls 410-662-5517 or email packet to Msmalls@familyleague.org.

This request will be reviewed by the LCT at our next scheduled weekly meeting. In general, the team meets on Tuesdays. We will respond to you by phone and/or mail. To leave a voice mail for the LCT Coordinator, please call: Moriah Smalls 443-872-4426.