CECIL COUNTY
LOCAL MANAGEMENT BOARD
LOCAL CARE TEAM

Cecil County Local Care Team Referral

Please complete the entire form to the best of your knowledge. An incomplete form may delay processing.
Return completed forms to: **localcareteam@cecilcountymd.gov**
Questions please contact 443-941-7066. Thank you!

Date: _____ **Referral Source Name:** _____

Agency: _____ **Phone:** _____ **Email:** _____

Referral Purpose:

☐ Assistance with connecting to potential resources
☐ Formal interagency discussion and development of an action plan
☐ Voluntary Placement Agreement discussion on VPA initiated through the Department of Social Services
☐ Direct service request for trauma therapy. Youth must be impacted by their caregiver's substance use to be eligible.
Please explain how the youth has been impacted by substance use:

Youth Name: _____ **DOB:** _____

Ethnicity: ☐ Hispanic, Latinx, or Spanish Origin ☐ Not Hispanic, Latinx, or Spanish Origin ☐ Prefer Not to Answer

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ Multiracial ☐ White ☐ Prefer Not to Answer

Gender: ☐ Male ☐ Female ☐ Transgender ☐ Non-Binary ☐ Other ☐ Prefer Not to Answer

Insurance: ☐ Private ☐ Medicaid

Current School: _____ **Grade:** _____ ☐ **IEP** ☐ **504** ☐ **None**

Concerns at School: ☐ Behavior ☐ Attendance ☐ Grades ☐ Other: _____

Current Living Situation: ☐ Parent ☐ Foster Care Relative: Role (i.e. Grandparent/Aunt/Uncle): _____
☐ Group Home ☐ Hospital ☐ Detainment ☐ Other _____

Parent(s)/Legal Guardians: _____

Address: _____

Cell/Phone: _____ **Email:** _____

Does Caregiver have legal custody of youth? ☐ **Yes** ☐ **No** ☐ **Unknown**

Reason for referral/event that prompted the referral:

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Mental Health Diagnosis (please check all that apply and provide diagnosis date if known):

☐ Acute Stress Disorder _____ ☐ Adjustment Disorder _____ ☐ Anxiety _____
☐ Attachment Disorder _____ ☐ Conduct Disorder _____ ☐ Depression _____
☐ Disinhibited Social Engagement Disorder _____ ☐ Obsessive Compulsive Disorder _____
☐ Oppositional Defiant Disorder _____ ☐ Post Traumatic Stress Disorder _____
☐ Reactive Attachment Disorder _____ ☐ Other:_____

Current Mental Health Provider(s): _____

Psychiatric Hospitalizations (Location, Dates):

Medical Hospitalizations (Location, Dates):

Developmental Diagnosis (please check all that apply and provide diagnosis date if known):

☐ Autism Spectrum Disorder _____ ☐ Attention Deficit/Hyperactivity Disorder _____
☐ Cerebral Palsy _____ ☐ Fetal Alcohol Spectrum Disorder _____ ☐ Fragile X Syndrome _____
☐ Hearing Loss_____ ☐ Intellectual Disability _____ ☐ Kernicterus _____
☐ Language & Speech Disorders _____ ☐ Learning Disorders _____ ☐ Muscular Dystrophy _____
☐ Vision Impairment _____ ☐ Other:_____

Other Agencies Currently Involved: ☐ Cecil County Health Department ☐ Developmental Disabilities Administration
☐ Department of Juvenile Services ☐ Department of Social Services ☐ Division of Rehabilitation Services
☐ Other: _____

Family Support System (friends, part of faith based community, extended family, mentor, etc.):

Additional Information:

Email to localcareteam@cecilcountymd.gov or mail to 200 Chesapeake Blvd. Suite 2521 Elkton, MD. 21921
Cell: 443.941.7066 Phone: 410.996.8048