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?

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?

Current school & grade:	
Please list any medical conditions:	☐ Allergy ☐ Anemia ☐ Asthma ☐ Birth Defects ☐ Bleeding Problems ☐ Cerebral Palsy ☐ Diabetes ☐ Ear Infections ☐ Food Allergy ☐ Genetic Disorder ☐ Head Injuries ☐ Headaches ☐ Hearing Problems ☐ High Blood Pressure ☐ High Cholesterol ☐ Immune Disorder ☐ Kidney Disorder ☐ Lead Poisoning ☐ Seizures ☐ Speech Disorder ☐ Sexually Transmitted Infection (STI) ☐ Thyroid Disorder ☐ Vision Problems ☐ Other:
Please list any behavioral challenges:	☐ Has challenges with effective communication, has difficulty reasoning or listening to another persons perspective ☐ Does not find activities interesting that were previously enjoyable ☐ Gets into physical fights with peers or family members ☐ Has challenges being honest and truthful or takes possession of itmes that may not belong to him/her/them ☐ Has a difficult time creating and building relationships with adults ☐ Has participated in self-harm (e.g., cutting or scratching self, attempted suicide) ☐ Appears sad or unhappy ☐ Has challenges building trusting relationships with friends, family or adults ☐ Finds home to be unsafe and/or has threatened to or has run away from home ☐ Finds it difficult to follow rules, laws or expectations ☐ Engages in inappropriate sexual behavior (e.g., sexually active, exhibits self, sexual abuse toward family members or others ☐ Becomes irritatble easily

Please list any behavioral challenges (cont'd):	☐ Has difficulty concentrating, thinking clearly, or attending to tasks ☐ Seems to engage others negatively when distracted or bored ☐ Can be demanding when needs are not met ☐ Experiences nightmares, difficulty with sleeping, oversleeping or waking up from sleep too early ☐ Can feel overly anxious or nervous ☐ Has friends of whom I don't approve ☐ Has difficulty making and keeping friends ☐ Has difficulty waiting his/her/their turn in activites or conversations ☐ Is triggered easily enough to be considered a threat to others or self
Please list any substance use	
Please list what services or agencies he/she/they has/ have been involved with up to now	

Meeting Purpose
Please explain why you are requesting an LCT meeting:

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 email the packet to lct@familyleague.org.

This request will be reviewed by the LCT at our next scheduled weekly meeting. We will respond to you by phone and/or mail. To contact the Local Care Team directly, please call: 443-662-5500.