Vermont Department of Education and
Agency of Human Services
Interagency Agreement

Section 2:
LIT, SIT or CRC Referral Forms

Version: April 9, 2009

For a CSP	➔	Complete Section 1
For referrals to LIT or SIT	➔	Complete Sections 1 & 2
For referrals to CRC	➔	Complete Sections 1, 2, & 3

Forms Being Submitted To
(please check all that apply) :

- ☐ Local Interagency Team (LIT)
- ☐ State Interagency Team (SIT)
- ☐ Case Review Committee (CRC)

Child/Youth's Name: _____

1. Release of Information for Interagency Team Review of *Coordinated Services Plan*

Child/Youth's Name	Lead Agency

Most Coordinated Services Plans (CSPs) get carried out. If, however, a CSP team does not agree with a plan, they may call upon the Local Interagency Team (LIT) for help. If the LIT cannot create a plan that everyone agrees with, the State Interagency Team (SIT) may be asked for help. If a CSP Team is thinking about wrap-around or residential care, then the CSP Team must ask the Case Review Committee (CRC) to review and consider this possibility.

I give my consent for the release of pertinent information including the Coordinated Services Plan (CSP) to the: Local Interagency Team (LIT), State Interagency Team (SIT), and/or Case Review Committee (CRC).

I understand that:

- My child's information includes records of educational, psychological, social history, medical evaluations, and services given to my child. My child's information also includes his or her CSP.
- My child's information will be shared with LIT, SIT, and/or CRC so that they can (1) review my child's CSP or (2) review the request for intensive wrap-around or residential care.
- I can look at or get a copy of the information about my child that is shared with LIT, SIT, and/or CRC by writing a letter to the lead agency.
- Members of LIT, SIT, and/or CRC know that my child's information is confidential they will not share information about my child with others without first getting my consent in writing unless the law says they must be shared.
- This consent form expires one year from the date that I sign it.
- I can take away my consent at any time by writing a letter to the lead agency, except for when LIT, SIT, or CRC has already used the information.
- If I do not give my consent, LIT, SIT, and/or CRC cannot (1) review my child's CSP or (2) review the request for intensive wrap-around or residential care.
- My child's current benefits and services will not be affected if I do not give my consent.
- I will be given a copy of this consent form after I sign it.
- General information about the usefulness of the coordinated services planning process is gathered by the State Interagency Team. Information from my child's referral documents may be used in this effort, but information on my child and family will not be identified.

I want to speak with my Local or State Interagency Team's parent representative before the LIT, SIT, or CRC meeting.	☐ Yes ☐ No

	Print Name	Signature	Date
Parent / Guardian			
Witness			
Educational Surrogate Parent (*if applicable*)			

2. Reason for Referral

Contact for Referral:			Phone:	
CSP and Referral Dates	CSP:	LIT:	SIT:	CRC:

A. What is the reason for referral to LIT/SIT/CRC? (*Attach documents including assessments, discharge summaries, service or treatment plans that support and provide information about the referral.*)

B. What gains are hoped for by this referral to LIT/SIT/CRC?

3. Youth's Living Situation

Please check the appropriate boxes to indicate the youth's previous, current, and proposed living situations and placements. Then use the box provided below to describe the youth's proposed living situation (including name of program if applicable).

Type (*check all that apply*)	**Previous**	**Current**	**Proposed**
Independent Living	☐	☐	☐
Two Caregivers (at least one biological)	☐	☐	☐
One Biological Parent Only (without partner)	☐	☐	☐
Shared Parenting	☐	☐	☐
Adoptive Home	☐	☐	☐
Relatives/Unpaid Adult	☐	☐	☐
Foster Care	☐	☐	☐
Therapeutic Foster Care	☐	☐	☐
Group Home	☐	☐	☐
Emergency Shelter	☐	☐	☐
Residential Treatment Program Assessment	☐	☐	☐
Residential Treatment - Long-term (non drug/alcohol)	☐	☐	☐

Drug/Alcohol Residential Treatment Program	☐	☐	☐
Medical Hospital	☐	☐	☐
Psychiatric Hospital	☐	☐	☐
Secure Juvenile Facility	☐	☐	☐
Correctional Facility	☐	☐	☐
Detention Alternatives	☐	☐	☐
No Place to Stay	☐	☐	☐
Other (*describe*):	☐	☐	☐
Other (*describe*):	☐	☐	☐
Other (*describe*):	☐	☐	☐
Please describe proposed living situation:			

4. Youth's Educational Situation

School Attending:		School where parent(s) reside:	
District:	Grade:	Contact (name & role):	Phone:

A. Special Education Status

☐ eligible; on IEP ☐ eligible; IEP pending	☐ need to refer ☐ assessed; found ineligible	☐ not applicable

Disability category:	Primary	Secondary	Other

If 16 years old or older, is transition plan included in IEP? ☐ Yes ☐ No

Special Education Admin:	Phone:

B. Section 504 Status

☐ eligible; on 504 plan ☐ eligible; 504 plan pending	☐ need to refer ☐ assessed; found ineligible	☐ not applicable

504 Coordinator:	Phone:

C. Educational Support Team Status

☐ EST plan in place	☐ need to refer	☐ not applicable

EST Coordinator:	Phone:

D. Educational Placement: *Check the boxes to indicate previous, current, & proposed educational placements.*

Kind of Placement (*check all that apply*)	**Previous**	**Current**	**Proposed**
Regular Classroom or child care	☐	☐	☐

Regular Classroom + in-class support and/or accommodations	☐	☐	☐
Regular Classroom + specialized instruction or other supports outside regular classroom (may include school-based EEE, Headstart)	☐	☐	☐
Separate Classroom	☐	☐	☐
Alternative School	☐	☐	☐
Day Treatment	☐	☐	☐
Tutorial	☐	☐	☐
Residential School	☐	☐	☐
Home and/or Hospital-based Instruction	☐	☐	☐
Not in school - graduated	☐	☐	☐
Not in school - obtained General Educational Development (GED)	☐	☐	☐
Not in school - dropped out	☐	☐	☐
Not in school - suspended	☐	☐	☐
Not in school - expelled	☐	☐	☐
Other (*describe*):	☐	☐	☐
Please describe proposed educational placement:			

5. Services and Agencies

Services	**Agency (*if known*)**	**Previous**	**Current**	**Proposed**
Child Care Services		☐	☐	☐
After School Program		☐	☐	☐
Mentoring		☐	☐	☐
Outpatient Psychological Assessment		☐	☐	☐
Behavior Support Services		☐	☐	☐
Case Management / Service Coordination		☐	☐	☐
Respite Services		☐	☐	☐
School-Based Clinician		☐	☐	☐
Family Counseling		☐	☐	☐
Group Counseling		☐	☐	☐
Individual Psychotherapy		☐	☐	☐
Intensive Family Based Services		☐	☐	☐
Home-based Parenting Support Services		☐	☐	☐
Parent Counseling		☐	☐	☐

Medication (Psychiatric)		☐	☐	☐
Community Skills Training		☐	☐	☐
Substance Abuse Treatment		☐	☐	☐
Vocational / Employment Services		☐	☐	☐
Children's Personal Care Services		☐	☐	☐
High Tech Nursing Services		☐	☐	☐
Traumatic Brain Injury Services		☐	☐	☐
Post Adoption Services		☐	☐	☐
Transportation		☐	☐	☐
Blind / Visually Impaired Services		☐	☐	☐
Deaf / Hard of Hearing Services		☐	☐	☐
Other (*describe*):		☐	☐	☐
Other (*describe*):		☐	☐	☐
Other (*describe*):		☐	☐	☐

6. Behavioral and Mental Health Information

Note: *This section is REQUIRED if child or youth has an* ***emotional disability*** *under the Act 264 definition, including, but not limited to, meeting the special education regulations for an emotional disability. If this does not apply, indicate NA and go on to the next page.*

A. Mental Health Status

DSM-IV Diagnosis	Code	Date	Provided by
1			
2			
3			
4			
Global Assessment of Functioning (GAF):			
List medications currently taken:			

B. Risk Factors (*check all that apply*):

Substantiated victim of: ☐ physical abuse ☐ neglect ☐ sexual abuse ☐emotional abuse	
☐ Adjudicated sex offender	☐ Substantiated perpetrator of sexual abuse
☐ Other adjudication (*describe*):	☐ Other risk factors (*describe*):

C. Behavioral Issues (*Please complete the checklist below. If the referral is through the Department of Mental Health please attach a recent [within the past three months] Child Behavior Checklist [CBCL].)*

In the last year has the child or youth exhibited any of the behaviors listed below to a marked degree when compared to others in his/her age group?

☐ confused/strange ideas	☐ impulsive	☐ extreme sadness
☐ inappropriate/bizarre behavior	☐ runs away	☐ anxiety
☐ inappropriate emotional reactions	☐ anti-social acts	☐ maladaptive dependence
☐ inappropriate attention	☐ fire setting/fire play	☐ somatic complaints
☐ hyperactivity	☐ refusal to accept limits	☐ bladder/bowel difficulties
☐ verbal aggression	☐ self-injurious behavior	☐ persistent school refusal
☐ aggression towards people	☐ suicidal thoughts	☐ school suspension
☐ aggression towards property	☐ suicidal behavior	☐ avoidance of social contact
☐ inappropriate sexual activity	☐ stealing	☐ serious sleep disturbance
☐ extreme withdrawal from family	☐ animal cruelty	☐ problems with the law
☐ substance abuse	☐ eating disorder	☐ experienced trauma
☐ other (*describe*):		
Feel free to expand upon the above behavioral issues and the settings in which they occur:		

7. Additional Information

A. Adoption Status

Is youth adopted? ☐ No ☐ Pending ☐ Yes
If yes, is there an adoption subsidy? ☐ No ☐ Yes, *If yes amount* $
If applying for residential treatment, does the DCF Adoption Unit know the family is applying for residential treatment? ☐ Yes ☐ No (*It is the family's responsibility to notify the Adoption Unit of such a change in residence for the child/youth*)

B. Custody Status

Is youth in DCF custody? ☐ No ☐ Yes
If yes, what is the custody status?
Is the youth Title IV-E eligible? ☐ No ☐ Yes
Parent(s)'s town of residence at time of custody:
Have parental rights been terminated (TPR)? ☐ No ☐ Yes
If yes, Parents' town of residence at time of TPR:

C. Legal Status

Does youth have contact with legal system? ☐ No ☐ Yes		
Guardian Ad Litem	Attorney	Probation Officer

D. Health Insurance and Supplemental Security Income

Does youth have health insurance? ☐ No ☐ Yes

If yes, what insurance?

☐ Medicaid - *Type if known*: ☐ Private - *Name if known:*

Please attach a copy of the medical insurance card(s). Without a copy of the medical insurance card(s), this referral may be delayed.

Does the child/youth receive Supplemental Security Income (SSI)? ☐ No ☐ Pending

☐ Yes, *If yes,* SSI amount: $