I. Each A-Team exists to:

A. Review cases concerning juvenile offenders (up to 20 years of age) who are identified by the respective Youth Court in each youth’s home county region as non-violent offenders who have serious behavioral or emotional disorders;

B. Facilitate the provision and coordination of the identified services and supports in the community; and,

C. Facilitate continuity of care for this target population and their families.

II. The Referral Source presenting the case agrees:

A. To refer only those youth/juveniles (up to 20 years of age) defined in Section I.A. above;

B. To notify the child’s/youth’s guardian/parent, youth services counselor, and/or other agency representative(s) that have been charged to serve the respective youth at the team meeting, to provide clarification; and,

C. To adhere to the prescribed referral process for utilization of this team, e.g., completion and return of the required Referral Form, etc, to the Team Coordinator.

III. The Host Agency is the Department of Human Services, Division of Youth Services:
Youth Services is responsible for coordinating the A-Team and identifying a facility for meetings.

IV. A-Team members representing the respective agencies/organizations agree to the following as per Mississippi Code 43-14-1 and 43-21-605 and other requirements.

A. The agencies represented must include a School Counselor, a Community Mental Health Center Professional, a DHS County Family and Children’s Social Services representative in the respective area, a Youth Services Counselor for the respective area, and a parent who has had a child in the juvenile justice system.

B. Cases reviewed will be those defined in Section I.A. of this agreement and as per Section 43-14-1 of the MS Code. Substance abuse/misuse can be co-occurring.
C. Additionally, as per this same State Code, the A-Team and its representative members are authorized:

1. To attend A-Team meetings and participate in developing a System of Care in the community for the youth.

OR

To send a representative to the A-Team meetings, as in the cases of statutorily named agencies that are required as per state statute to participate in developing a system of care in the community for the youth.

Note: Each Community Mental Health Center with a county or counties in the respective A-Team DYS Region will send a mental health professional with a master’s degree at a minimum, from children and youth behavioral health services to those meetings at which the case of a youth from the respective CMHC region will be addressed. It is the responsibility of the A-Team Coordinator to notify the CMHC representatives needed for each A-Team meeting.

Where meetings are to be held:

<table>
<thead>
<tr>
<th>Name of Facility/Building</th>
<th>Location/Address</th>
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<tbody>
<tr>
<td>Date/Day of Month for Meeting</td>
<td>Time of Day</td>
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</table>

2. To identify community-based services for the targeted non-violent juvenile offenders;

3. To facilitate the provisions and coordination of services across agencies/entities for the targeted non-violent population;

4. To facilitate continuity of care for non-violent juvenile offenders with serious behavioral or emotional disorders and their families;

5. To maintain confidentiality regarding all information discussed during the meeting and decisions regarding services for a youth.
Mississippi Department of Human Services, Division of Youth Services  
A-Team Memorandum of Agreement-Page 3 of 4

6. To utilize the terms of this agreement for one year, at which time the annual Memorandum of Agreement revision and renewal process will be completed.

Additionally, the A-Team Coordinator agrees

1. To maintain documentation on each youth of Team actions/recommendations;

2. To inform the Team Members of any invited guest(s) prior to a scheduled Team meeting, and,

3. To have the right to refuse invited guest(s) who have had prior conflict with the courts or members.

V. Monthly Reporting: Monthly reports will be submitted to the state A-Team Coordinator, Community Services Director in the Division of Youth Services as required in addition to any reports requested by local/state agencies participating in this Team.

VI. Signatures

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<tr>
<th>Signature</th>
<th>Printed Name</th>
<th>Date</th>
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<tr>
<td>DHS/DYS Regional Director</td>
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<td>DHS Family Children Social Services Regional Director</td>
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<td>CMHC Executive Director*</td>
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*Each CMHC with counties within the respective A-Team region must have an appropriate signature from each CMHC region.
Memorandum of Agreement Period:
(One year from date of last signature)
A-Team Confidentiality Statement
Signed by A-Team Members and Others Present PRIOR to Reviewing the case of each individual youth

Confidentially Statement for:

Name __________________________ SS# __________________________

I affirm that
I shall respect the privacy of the youth and their families, holding in confidence all information obtained in the course of interagency collaboration and A-Team meetings. Therefore, I will not disclose case confidences to anyone, except as mandated by law.

I shall possess a professional attitude that upholds confidentiality towards the youth, their families, colleagues, and any sensitive situations that arise in the community.

I will work cooperatively and collaboratively with others focused on maintaining confidentiality and serving the clients and families through the A-Team process.

My signature below is evidence of my adherence to the A-Team Confidentiality Statement.

DATE REVIEWED __________________________

DHS/DYS Regional Director __________________________

DHS/DYS Youth Court Counselor __________________________

DHS Family and Children Services Representative __________________________

CMHC Representative __________________________

School Counselor or Attendance Officer __________________________

Parent Representative __________________________

Referring DHS/DYS Counselor __________________________

Signature Representing __________________________

Signature Representing __________________________

Signature Representing __________________________

Signature Representing __________________________
CASE INFORMATION

Name __________________________________________ SS# ________________________________________

1. Previous Out of Home or Residential Placements: Yes or No
   If yes—Name __________________________ Type/Facility ________________________________
   Location __________________________ Time Period(s) ________________________________
   Facility Recommendations ________________________________________________________

Facility Recommendations ________________________________________________________
   Name __________________________ Type/Facility ________________________________
   Location __________________________ Time Period(s) ________________________________

2. MDHS Custody Placements: Yes or No
   If yes—# of Foster Homes _____ Reasons for removal/replacements & Time Periods
   #1. __________________________________________________________
   #2. __________________________________________________________

3. Review DYS Social History Attached and provide the following information.

<table>
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<tr>
<th>Strengths of Youth</th>
<th>Strengths of Family</th>
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4. Education History (Attach available current information)
   Current School/Most recent attended & dates ________________________________________
   City/County/State __________________________ Grade Level ______ Grades ___________
   Sp Ed: Yes or No Eligibility Ruling __________________________
   Disciplinary Actions: Yes or No Suspension (date) _____; Expulsion (date) __________
   Alternative School: Yes or No Dates: ____________________________________________

5. Medical History (Attach available current information)
   Allergies __________________________ Physical Impairment __________________________
   Surgery __________________________
   Current or Chronic Disease __________________________
   Pertinent Family Medical History ____________________________________________

Other Pertinent Medical Information ____________________________________________

Confidential Information Collected for DHS Division of Youth Services A-Team
6. Mental Health History

Has the Youth been reviewed by MAP Team? Yes or No Explain ____________________________

Receiving Mental Health Services: Yes or No If yes, check appropriate services:
   _ outpatient therapy _ case management _ day treatment _ physician services
   _ medications (Identify)

Agency providing mental health services & duration: ________________________________

Hospitalized for psychiatric treatment: Yes or No If yes, give location/attach discharge
   summary, if available: _______________________________________________________

Other important information including pertinent family history: ___________________
   ____________________________

7. Review the Resources for this Youth currently being assessed by youth and family:

<table>
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<tr>
<th>Name</th>
<th>Type/Facility/Agency</th>
<th>Dates</th>
<th>Location</th>
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Identify any other resources that have been contacted or might be appropriate to contact for this client and
the client’s family.

8. Please provide any additional pertinent information below or on a separate sheet.
A – Team Recommendations

Name ___________________________________________ SS# __________________________

Why was this client referred to the A-Team?

Recommendations:

1. Educational Recommendations
2. Mental Health Recommendations
3. Youth Services Recommendations
4. Family & Children/Social Services Recommendations
5. Other recommendations

A-Team Member Signature ___________________________________________ Date _____________

1. DHS/DYS Regional Director ___________________________________________
2. DHS/DYS Representative Counselor ________________________________
3. DHS Family & Children Services/Social Services Rep ____________________
4. CMHC Representative _____________________________________________
5. School Counselor/School Attendance Officer __________________________
6. Parent Representative _____________________________________________
A-Team Release Form
Authorization to Release or Obtain Protected Health Information

Name ____________________________ County __________________

Sex ____________________ Date of Birth ____________________ Social Security Number ____________________

Authorized Representative (if applicable) _____________________________________________________________

I, ____________________________ or I, as the ____________________________, authorize (Name)
(paragraph/guardian/other judicially authorized person)

_______________________________ to release or obtain (circle one) my protected health information records to/from
(Name of person/title of entity and address to whom/from whom information will be disclosed/obtained).

I specifically authorize/consent to the release or obtaining (circle one) of health information/records pertaining to the following: __________________________

for the specific purpose of __________________________

Dates of Service for which information/record is requested or will be released from ________________ to ________________

I understand that I have the right to revoke this authorization at any time. I understand that to revoke this authorization, I must provide a specific request to revoke the authorization in writing to any A-Team member.

I understand that my revocation will not apply to action or any information that has already been released/obtained in response to this authorization.

I understand that my authorizing the disclosure/obtaining of this health information is voluntary. I understand that I may inspect or copy information to be used or disclosed as provided by law. I understand that any disclosure of information carries with it the potential for disclosure and that the information may no longer be protected by federal confidentiality laws.

______________________________ ______________________
Signature of Individual Date

______________________________ ______________________
Signature of Parent/Guardian/Judicially Authorized Representative Date

______________________________ ______________________
Signature of Witness Date
A-Team Tracking Form

Name_________________________________Social Security Number_____________________
Contact Person_________________________Telephone______________________________

This case presented initially to the A-Team on will be tracked by the A-Team based on the recommendations and timelines provided. The first review date is scheduled for _________________.

1. Reviewed on _________________. Comments/Needs at the time of review:
   __________________________________________________________________________
   Next scheduled review date ________________________________________________

1. Reviewed on _________________. Comments/Needs at the time of review:
   __________________________________________________________________________
   Next scheduled review date ________________________________________________

1. Reviewed on _________________. Comments/Needs at the time of review:
   __________________________________________________________________________
   Next scheduled review date ________________________________________________

1. Reviewed on _________________. Comments/Needs at the time of review:
   __________________________________________________________________________
   Next scheduled review date ________________________________________________

1. Reviewed on _________________. Comments/Needs at the time of review:
   __________________________________________________________________________
   Next scheduled review date ________________________________________________

Case Closed or continue A-TEAM services with next A-TEAM Review or Other Referral
____________________________________________________________________________

Confidential Information Collected for DHS Division of Youth Services A-Team
Page 7 of 8
Referral to State Level Case Review Team

SPECIAL NOTE: The Complete A-Team Referral Packet and its attachments serve as the State Level Case Review Referral Packet.

To be completed by Referring A-Team

Date_______ Referring DHS/DYS Regional Director __________________________

Telephone________________________

Name of Youth____________________ DOB ______ Race ______ Sex ______

SS#____________________ Telephone________ Medicaid/Insurance________

Reason for Referral to State Level Case Review Team

To be completed by State Case Level Review Team

Recommendations:

Signature __________________________ Date ______