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:

   _____

   Name of Facility/Building Location/Address

   _____

   Date/Day of Month for Meeting Time of Day

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.

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

Signature-DHS/DYS Regional Director	Printed Name	Date
Signature-DHS Family /Children Social Services Regional Director	Printed Name	Date
Signature-CMHC Executive Director*	Printed Name	Date
Signature-CMHC Executive Director*	Printed Name	Date
Signature-CMHC Executive Director*	Printed Name	Date
Signature-CMHC Executive Director*	Printed Name	Date
Signature-CMHC Executive Director*	Printed Name	Date

*Each CMHC with counties within the respective A-Team region must have an appropriate signature from each CMHC region.

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A-Team Memorandum of Agreement-Page 4 of 4

Signature-DHS/DYS County Counselor	Printed Name	Date
Signature-School Counselor/ School Attendance Officer	Printed Name	Date
Signature-Parent Representative	Printed Name	Date
Signature	Printed Name	Date
Signature	Printed Name	Date
Signature	Printed Name	Date
Signature	Printed Name	Date
Signature	Printed Name	Date
Signature	Printed Name	Date
Signature	Printed Name	Date
Signature	Printed Name	Date
Signature	Printed Name	Date
Signature	Printed Name	Date

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

Confidential Information Collected for DHS Division of Youth Services A-Team
1 of 8

INTRODUCTION INFORMATION

Date of Referral_____ DHS/DYS Region _____

Referring Counselor_____Location_____

Date of Court Hearing_____

Name of Youth_____DOB_____Race_____Sex____

Address_____

SS #_____Telephone_____Medicaid/Ins._____

Mother_____Telephone_____Employment_____

Address_____

Father_____Telephone_____Employment_____

Address_____

Legal Guardian/Custodian_____Telephone_____

Employment_____Address_____

Current Charges

Previous Violation of Probation of Parole

Brief Summary of Court History (Also Attach Offense Sheet)

Brief Summary of Mental Health (Please report any additional information regarding the youth's mental health and the behaviors consistently demonstrated by the youth. Also attach current psychological or CMHS Intake and/or Treatment Plan, if available)

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_____

   Name_____Type/Facility_____

   Location_____ Time Period(s)_____

   Facility Recommendations_____

2. MDHS Custody Placements: Yes or No

   If yes--# of Foster Homes _____Reasons for removal/re-placements & Time Periods
   #1._____
   #2._____

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

Strengths of Youth	Strengths of Family

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_____

NAME_____SS #_____

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:

Name_____Type/Facility/Agency_____

Dates_____Location_____Cost_____

Name_____Type/Facility/Agency_____

Dates_____Location_____Cost_____

Name_____Type/Facility/Agency_____

Dates_____Location_____Cost_____

Name_____Type/Facility/Agency_____

Date_____Location_____Cost_____

Name_____Type/Facility/Agency_____

Dates_____Location_____Cost_____

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) (parent/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 _____

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 _____

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