Fulton County Juvenile Court

Dually Involved Youth Multidisciplinary Team (MDT) Staffing Form

MDT Date & Time: _____ Next Court Date: _____

MDT Facilitator: _____ Court Room: _____

Consent to share information reviewed and signed: ☐ Yes (please attach form) ☐ No (list reason):

Confidentiality statement reviewed and signed: ☐ Yes (please attach form) ☐ No (list reason):

YOUTH's Name	**Date of Birth**	**File #** **Case #**
Placement Address	**Date of Original Placement**	**Date of Current Placement**
Parent/Legal guardian's Name	**Phone #**	**Phone #**
Parent/Legal Guardian's Address		

CURRENT YOUTH INVOLVEMENT
☐ FAMILY SUPPORT ☐ CPS INVESTIGATION ☐ FAMILY PRESERVATION ☐ FOSTER CARE Date entered Care:
☐ CHINS REGISTRY ☐ CHINS COMPLAINT ☐ DELINQUENCY COMPLAINT ☐ DELINQUENCY (from Superior Court)
YOUTH DETAINED?: ☐ N/A ☐ YES ☐ NO (DATE OF DETENTION): _____ (DATE OF RELEASE): _____

Multidisciplinary Team (MDT) Meeting MDT Type/Time Frame
Detained Youth: ☐ INITIAL MDT WITHIN 5 DAYS OF DETENTION HEARING: ☐ YES ☐ NO (LIST REASON): _____ (Prior to 10 Day Adjudication) _____ **Non-Detained Youth**: ☐ INITIAL MDT WITHIN 10 BUSINESS DAYS OF COMPLAINT/REFERRAL: ☐ YES ☐ NO (LIST REASON):

☐ MDT PRIOR TO DISPOSITION: ☐ YES ☐ NO (LIST REASON): _____

☐ FOLLOW UP MDT (Quarterly; more often if necessary)

☐ NO CONTACT WITH CHILD/PARENT WHY NOT? _____

Multidisciplinary Team (MDT) Staffing MDT Participants/Invitees						
Role in relation to Youth	**Name**	**Phone Number(s)/Email**	**Invited to MDT**		**Present at MDT**	
			Yes	**No**	**Yes**	**No**
Parent			☐	☐	☐	☐
Parent			☐	☐	☐	☐
Youth			☐	☐	☐	☐
Sibling(s)			☐	☐	☐	☐
Relative Caregiver			☐	☐	☐	☐
Foster Parent			☐	☐	☐	☐
DFCS Case Mgr.			☐	☐	☐	☐
DFCS MDT Liaison			☐	☐	☐	☐
CPA/CCI Representative			☐	☐	☐	☐
Probation Officer			☐	☐	☐	☐
CASA/GAL			☐	☐	☐	☐
TIP GA Volunteer			☐	☐	☐	☐
School Representative			☐	☐	☐	☐
Provider for Parent			☐	☐	☐	☐

Provider for Youth			☐ ☐	☐ ☐
Parent Advocate			☐ ☐	☐ ☐
OCA Representative			☐ ☐	☐ ☐
			☐ ☐	☐ ☐
			☐ ☐	☐ ☐
			☐ ☐	☐ ☐
			☐ ☐	☐ ☐

Educational History

Current School: _____ Grade Level: _____
Address: _____ Phone Number: _____

Has youth ever been retained? ☐ Yes ☐ No
If yes, what grade and
why?_____

Has youth ever been suspended or expelled? ☐ Yes ☐ No
If yes, what grade and
why?_____

Has youth received any services put in place by the school? ☐ Yes ☐ No
If yes, when and type of service?
_____

Does Youth have an Individualized Education Program (IEP) that outlines the Youth's educational goals and objectives? ☐ Yes ☐ No
If so, next IEP review date: _____
Was a copy of the IEP obtained by the MDT? ☐ Yes ☐ No ☐ N/A
List the Youth's primary and secondary exceptionality:
_____

Does the IEP include a Behavior Intervention Plan? ☐ Yes ☐ No ☐ N/A
Does the youth have a 504 Plan? ☐ Yes ☐ No ☐ N/A
Was a Functional Behavior Assessment completed? ☐ Yes ☐ No ☐ N/A
Has Youth been referred to EPAC? ☐ Yes, Date Referred _____
☐ No, Reason _____

_____

☐ N/A (Youth NOT in Foster Care)

Medical History

Is youth currently under the care of a physician for any chronic medical issues? ☐ Yes ☐ No ☐ N/A

If yes, who and where? _____

Reason/Dx: _____

Is youth currently prescribed medication(s) for general health issues? ☐ Yes ☐ No ☐ N/A

If yes, document name of medication, dosage, reason prescribed, and prescribing physician

_____

_____

Does youth have medical insurance coverage? ☐ Yes ☐ No ☐ N/A

If yes, name of Provider _____

Is Insurance currently active? ☐ Yes ☐ No ☐ N/A

Behavioral Health History

Is youth currently receiving mental health services (counseling/psychotherapy)?

☐ Yes ☐ No ☐ N/A

If yes, who is youth currently seeing? _____

If youth is NOT currently receiving services, has a referral been made for services?

☐ Yes ☐ No ☐ N/A

Referred to: _____ Referred by:_____ Date of Referral:_____

Has youth received mental health services in the past? ☐ Yes ☐ No ☐ N/A

If yes, whom did youth see and when? _____

Have youth ever been in the hospital for treatment of mental illness? ☐ Yes ☐ No ☐ N/A

If Yes, when and where was youth hospitalized? _____

Is youth currently on any prescribed mental health medications? ☐ Yes ☐ No ☐ N/A

If yes, document name of medication, dosage, reason prescribed, and prescribing physician:

_____

MAYSI-2 results for detained youth

Substance Abuse (add language)

Systems History

Does youth have ***prior*** Court involvement? ☐ Yes ☐ No

If yes, type of involvement? ☐ CHINS REGISTRY ☐ CHINS COMPLAINT ☐ DELINQUENCY COMPLAINT

☐ DELINQUENCY ☐ DJJ COMMITMENT ☐ OTHER _____

(from Superior Court)

County, State: _____ When? _____

Outcome? _____

Does youth (family) have ***prior*** Child Protective Services involvement? ☐ Yes ☐ No

If yes, type of involvement? ☐ FAMILY SUPPORT ☐ CPS INVESTIGATION ☐ FAMILY

PRESERVATION ☐ FOSTER CARE (Date entered Care: _____) # of Placements?_____

What was the permanency plan for the Youth? ☐ N/A (Youth not removed from home)
☐ Reunification ☐ Adoption ☐ Guardianship ☐ Fit and Willing Relative
☐ Another Planned Permanent Living Arrangement (APPLA)
Date permanency achieved? _____
Comments: _____

Support Network for Youth

Immediate Family:	☐ Yes	☐ No	Extended Family:	☐ Yes	☐ No
Friends:	☐ Yes	☐ No	School/Work:	☐ Yes	☐ No
Religious/Spiritual:	☐ Yes	☐ No	Community:	☐ Yes	☐ No
Mentor:	☐ Yes	☐ No	Other:	☐ Yes	☐ No

Describe the Current Support System for the Youth:

_____
_____
_____

NAME EMAIL PHONE

Support Network for Parent(s)/Guardian(s)

Immediate Family:	☐ Yes	☐ No	Extended Family:	☐ Yes	☐ No
Friends:	☐ Yes	☐ No	School/Work:	☐ Yes	☐ No
Religious/Spiritual:	☐ Yes	☐ No	Community:	☐ Yes	☐ No
Parent Advocate:	☐ Yes	☐ No	Other:	☐ Yes	☐ No

Describe the Current Support System for the Parent(s)/Guardian:

_____
_____
_____

NAME EMAIL PHONE

Family Focused Strengths and Needs

Families should be involved in a strengths-based, solution-focused team that values the families' voice and focuses on the child's safety, permanency, and well-being (Annie. E. Casey Foundation & Casey Family Services, 2009).

Family Strengths/Resources/Supports	Growth Areas/Need Development

Goals / Description of Action or Services	Responsible Person(s)	Due Date Time Frame
Goal 1: Action Plan:		
Goal 2: Action Plan		
Goal 3: Action Plan		

Concerns/Barriers/Challenges:

_____
_____
_____
_____
_____
_____

Recommendation(s) for Youth (including Youth's goals/interests for self) (more specific after adjudication)

Received by Youth's Public Defender: ☐ Yes ☐ No ☐ N/A

Public Defender's Name and Contact information:

_____

Received by Youth's Child Attorney: ☐ Yes ☐ No ☐ N/A

Child Attorney's Name and Contact Information:

_____

Acknowledgement of Receipt Date: _____