Department of Health & Human Services
Division of State Operated Healthcare Facilities
Developmental Centers

Referral for Admission

☐ **Statewide Programs –** Murdoch Developmental Center ☐ PATH ☐ STARS

☐ **Western Region –** J. Iverson Riddle Developmental Center ☐ Adult ICF ☐ Respite

☐ **Central Region –** Murdoch Developmental Center ☐ Adult ICF ☐ Respite

☐ **Eastern Region –** Caswell Developmental Center ☐ Adult ICF ☐ Respite

MCO: **MCO Contact:**

Telephone:

County of Residence: Email Address:

SECTION I: APPLICANT INFORMATION

Date of Referral: _____

Previous Admission(s)/Date(s): _____

Name: _____
Last First Middle Preferred Name

Current or Most Recent Living Environment: Innovations Waiver: ☐ Yes ☐ No

☐ Family Home ☐ Supported Living/AFL ☐ IDD group home ☐ MH group home
☐ ICF-IID ☐ Skilled Nursing Facility ☐ Adult Care Home/Assisted Living
☐ Other (please specify): _____

Is the applicant currently in any of the following:
☐ Acute Crisis/ED Setting ☐ State Psychiatric Hospital ☐ Other Hospital/PRTF ☐ Jail/Detention
Facility: _____ Date of Admission: _____

Residential Provider/Facility (if applicable): _____

Address: _____
Street/Mailing City State ZIP Code

Telephone: _____

Sex: _____ Race: _____ Marital Status: _____ Language: _____ US Citizen?

Date of Birth: _____ County/State/Country of Birth: _____ / /

Medicaid: ☐ Yes ☐ No Medicaid # **Medicare:** ☐ Yes ☐ No Medicare #
☐ Private Insurance:

Date of Referral:

SECTION II: SYSTEM OF SUPPORT CONTACTS

If over 18, has the applicant been adjudicated incompetent? ☐ No ☐ Yes *(Provide contact for identified primary support person under section below)*

Type of Guardianship: _____

County Adjudicated: _____ Date of Qualification: _____

Legally Responsible Person/Agency: _____

Address: _____
Street/Mailing City State ZIP Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____

Name: _____ Relationship: _____

Address: _____
Street City State ZIP Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____

Name: _____ Relationship: _____

Address: _____
Street City State ZIP Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____

Name: _____ Relationship: _____

Address: _____
Street City State ZIP Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____

Comments on support network:

Date of Referral:

SECTION III: OVERVIEW OF NEED

Include date, score, and assessment type for IQ

Intellectual/Developmental Disability:

Include age of diagnosis, subtype, sensory needs

Autism Spectrum Disorder:

Psychiatric Diagnoses:

Medical Diagnoses:

Social Stressors and/or Trauma History:

Self-Care Skills: I=Independent VP=Verbal Prompt PA=Physical Assistance TD=Total Dependence

_____ Eating/Drinking
_____ Toileting
_____ Bathing/Grooming
_____ Dressing/Undressing, including closures
_____ Teeth Brushing
_____ Hand washing

Mobility:

☐ Independent ☐ Requires Assistance ☐ Non-Ambulatory/Mobile ☐ Non-Ambulatory/Non-Mobile

Life Skills: I=Independent VP=Verbal Prompt PA=Physical Assistance TD=Total Dependence

_____ Choosing/Preparing Simple foods
_____ Household Chores (dishes, laundry, making bed, etc.)
_____ Making Phone Calls
_____ Pedestrian Safety Skills
_____ Making Simple Purchases

Date of Referral:

Communication/Language:

Expressive:

☐ Uses expressive language Mode: ☐ Verbal ☐ Sign Language ☐ Gesture

☐ Uses communication device Specify Type:

Receptive:

☐ Comprehends verbal language ☐ Attends to gestures and auditory cues ☐ Attends to visual cues

☐ Does not respond to communication

Describe how the applicant makes his/her wants and needs known:

Socialization:

☐ Initiates interaction ☐ Responds to interaction ☐ Avoids interaction

☐ No response to interaction ☐ Prefers interaction with males ☐ Prefers interaction with females

Sexual Awareness:

Is the applicant aware of his/her sexuality? ☐ Yes ☐ No Sexually active? ☐ Yes ☐ No

If yes to either above, describe any concerns or matters we should know in order to support the applicant:

Leisure:

Favorite Leisure Activities

SECTION IV: BEHAVIORAL HEALTH NEEDS

Is there a current behavior support plan? ☐ Yes – Psychologist name/contact:

☐ No – Reason:

BEHAVIOR	**FREQUENCY** How often does this occur?	**DESCRIPTION** What does this look like for this person?
Verbal Aggression		
Physical Aggression		
Property Destruction		
Elopement/Wandering		
Self-Injurious Behavior		
Inappropriate Sexual Behavior		
PICA		

Has the applicant been charged with and/or convicted of any criminal offenses? ☐ Yes* ☐ No

(*If Yes, please complete Legal History form)

SECTION V: CURRENT SUPPORTS AND SERVICES

NC START Involvement:

Region: _____ Date of Referral: _____ Outcome of Referral: _____

Coordinator Name (if active): _____ Phone # _____

Education:

Is the applicant currently in school? ☐ No – Highest Grade/Program Completed:
☐ Yes – Complete the following and IEP must be included with referral

Name of School: _____ Current Grade: _____

Contact Name: _____ Phone # _____

Classroom Setting: ☐ Integrated ☐ Self-Contained ☐ 1:1 ☐ Home-Based (# of Hours:)

Vocation/Day Activity:

Describe applicant's daily schedule. Include employment history as appropriate.

Active Services (currently working with the applicant):

Provider	Service/Hours	Date of Auth	**Notes** (How effective is the support provided?)