# Universal Child and Adolescent Residential Placement Referral Form

## Instructions for completion:

Consistent with System of Care principles, the Universal Child and Adolescent Residential Placement Application offers a comprehensive clinical review of a child's/adolescent's needs for purposes of admission to a residential provider contracted with any of the six North Carolina Local Management Entities/Managed Care Organizations (LME/MCOs). Please note: All references to "member" in this form refer to a Medicaid member or a State-funded Services recipient.

**Please follow the instructions below:**

1 This application should be completed in its entirety. Answer each question to the best of your ability, indicating not applicable or not available where appropriate. Applications may be returned to the referring party if deemed incomplete.

2 Do not enter "see attached" in sections requiring specific detail. If you have a document that provides greater detail than can be entered, reference the document name, date, and page number at the end of your explanation. (e.g., Physical Assessment, 07.01.15, page 3). Submit any reference documentation along with this application.

3 The person completing this application is responsible for obtaining necessary releases/authorizations to disclose protected health information.

4 The Universal Application must be signed by the legally responsible person as defined at N.C.G.S. § 122C-3(20): "a parent, guardian, a person standing in loco parentis, or a legal custodian other than a parent who has been granted specific authority by law or in a custody order to consent for medical care, including psychiatric treatment."

**Disclaimer:** This form was created for the convenience of referring agencies and individuals to streamline discharge planning and to eliminate time and redundancy associated with multiple, agency-specific placement applications. However, the use of this form does not, and should not be construed to guarantee authorization of residential or other treatment by the applicable LME/MCO or admission by any eligible provider. Moreover, responsibility for appropriate discharge from inpatient facilities remains with the discharging provider.

| **Date referral form completed:** | **Date service needed:** |
|---|---|
| **Type of referral/Level of Care sought**<br>☐ Residential Level I – Family type<br>☐ Residential Level II – Family type<br>☐ Residential Level II – Program type<br>☐ Residential Level Ill – Group home<br>☐ Residential Level IV – Secure<br>☐ Psychiatric Residential Treatment Facility (PRTF)<br>☐ Emergent Need Respite – internal referrals only<br>☐ Residential Supports, Alternative Family Living (AFL) – NC Innovations Waiver | ☐ Residential Supports, Group home – NC Innovations Waiver<br>☐ Non-Medicaid-Funded Residential Services – Group home or AFL<br>☐ Long-Term Community Supports – intellectual/developmental disability (I/DD) residential services (Medicaid)<br>☐ Individual Supports – Mental health (Medicaid)<br>☐ Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) |
| **Member name:** | |
| **Is the member a Medicaid beneficiary?** ☐ Yes ☐ No | **If yes, Medicaid ID#:** |
| **LME/MCO or PHP benefit plan:** | |
| **Does the member have a CCA?** ☐ Yes ☐ No | **If yes, date of most recent CCA:** |
| *Note: A CCA is required to approve the placement of a child/youth in a leveled Medicaid-supported plan.* | |

## 1. REFERRAL SOURCE INFORMATION

**Referring agency:** ☐ Hospital ☐ Clinical home agency ☐ DJJ ☐ DSS, county: _____
☐ Other: _____

| | |
|---|---|
| **Name of referring agency:** | |
| **Contact person:** | **Phone number:** |
| **Alternate contact number:** | **Fax number:** |
| **Reason for referral:** | |

## 2. MEMBER DEMOGRAPHIC INFORMATION

| | | |
|---|---|---|
| **Member name:** | | **Preferred name:** |
| **Date of birth:** | **Age:** | **Gender assigned at birth:** ☐ Male ☐ Female |
| **Gender identity:** | **Pronouns:** | **Sexual orientation:** |
| **Race:** | **Place of birth:** | |
| **Primary language:** | | **Does the member speak English?** ☐ Yes ☐ No |
| **County from which Medicaid originates:** | | |
| **What counties are you open to placement in?** ☐ Any ☐ Specific counties (please list below) | | |
| **Current living arrangement:** | | |
| **Special considerations:** *(Examples include safety concerns, no pets, needs to be LGBTQ competent, can't share a bedroom, no other children in the home, gender- specific parent, single parent home, etc.)* | | |
| **Describe the skill set that potential resource parents, caretakers, or staff will need to serve this child/ youth (this helps to identify the best possible placement):** | | |

## 3. LEGALLY RESPONSIBLE PERSON INFORMATION

| | |
|---|---|
| **Who is legally responsible for the child?** ☐ Parent ☐ Guardian ☐ County DSS ☐ Other | |
| **Name of guardian/custodian:** | **Relationship to member:** |
| **If in DSS custody, county of legal custody:** | **Permanency plan:** |
| **Has there been a termination of parental rights?** ☐ Yes ☐ No<br>**If yes, date and by whom:** | |

| | | |
|---|---|---|
| **Home phone:** | **Work phone:** | **Mobile phone:** |
| **Mailing address:** | **Email:** | |

## 4. FAMILY INFORMATION

**Is the member adopted?** ☐ Yes ☐ No

**What distance is the family willing/able to travel to be involved in the child's treatment?**

**Are there religious, spiritual, or cultural considerations?**

**Are there existing visitations?** ☐ Yes ☐ No

**Are the visits supervised?** ☐ Yes ☐ No

**If yes, by who?**

**If there are existing visitations, with whom, where, and how often?** *(Visits can include birth parents, grandparents, siblings, former foster parents, and other important connections for the child/youth.)*

**Does the member have siblings?** ☐ Yes ☐ No

**If yes, list their first names:**

**Are you seeking placement of the siblings together?** ☐ Yes ☐ No

**If yes, which siblings?**

## 5. CLINICAL/DIAGNOSTIC INFORMATION

**DSM-5 – DIAGNOSTIC INFORMATION**

| CODE | DIAGNOSIS |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

| Primary diagnosis: | Secondary diagnosis: |
|---|---|

**IQ:** ☐ High-functioning ☐ Average-functioning ☐ Low-functioning

## 6. MEDICATION INFORMATION

☐ **MEDICATION LIST ATTACHED** (If list attached, it is not necessary to complete this section.)

| MEDICATION | DOSE/ROUTE |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

## 7. TREATMENT AND PLACEMENT HISTORY

| | |
|---|---|
| **Number of out-of-home placements:** | |
| **Has the member been hospitalized?** ☐ Yes ☐ No | **If yes, how many times in the past year?** |
| **Has the member been in residential placement in the past year?** ☐ Yes ☐ No<br>**If yes, where?** | |
| **Has the member had a psychosexual evaluation?** ☐ Yes ☐ No<br>**If yes, date of most recent:** | |
| **Has the member had a trauma evaluation?** ☐ Yes ☐ No<br>**If yes, date of most recent:** | |
| **Has the member received trauma treatment?** ☐ Yes ☐ No<br>**Describe:** | |

## 8. CURRENT SYMPTOMS/OBSERVATIONS

**Check all that apply. Provide specific details and/or the date of last incident, if known and applicable.**

| | | |
|---|---|---|
| ☐ Abandonment issues | ☐ Anxiety | ☐ Difficulties at school |
| ☐ Stool/feces smearing | ☐ Sexually inappropriate behavior | ☐ Fire-starting/arson |
| ☐ Bedwetting | ☐ Eating disorder behaviors | ☐ Problems with sleep |
| ☐ Property destruction | ☐ Homelessness | ☐ Hyperactivity |
| ☐ Impulsivity | ☐ Lying | ☐ Low self-esteem |
| ☐ Loss/grief | ☐ Phobias | ☐ Sibling-related difficulty |
| ☐ Oppositional | ☐ Social immaturity | ☐ Stealing |
| ☐ Truancy | ☐ Cruelty to animals | ☐ Hygiene/cleanliness issues |
| ☐ Hygiene/cleanliness issues | ☐ Gang-related activity | ☐ History with weapons |

**Abuse/trauma history:** ☐ None ☐ Victim of neglect ☐ Victim of physical abuse ☐ Victim of sexual abuse ☐ Witness to any of the above ☐ Other trauma (e.g., natural disaster, fire, car crash, violence, systemic racism)

**If any of the above options are checked, provide a brief description:**

## 9. RISK ASSESSMENT

☐ **Self-injurious behavior**

**Check all that apply:** ☐ Cuts on body ☐ Conceals cutting, *indicate area:* _____ ☐ Other forms of self-injury, *Describe:* _____

**Has self-injury ever required medical attention?** ☐ Yes ☐ No

**Explain:**

☐ **Suicidal characteristics**

**Check all that apply:** ☐ Suicidal thoughts ☐ Past suicide attempts ☐ Suicidal plans

**If checked above, describe:**

**Describe methods used in previous attempts:**

**Were attempts planned?** ☐ Yes ☐ No ☐ Sometimes ☐ Unknown

☐ **Homicidal characteristics**

**Check all that apply:** ☐ Homicidal thoughts ☐ Past attempts to harm others ☐ Homicidal plans

**If checked above, describe:**

**Describe methods used in previous attempts:**

**Were attempts planned?** ☐ Yes ☐ No ☐ Sometimes ☐ Unknown

**Does the member have access to weapons?** ☐ Yes ☐ No

**Explain:**

☐ **History of elopement**

**Check all that apply:** ☐ Runs away from home ☐ Has run from previous placements

**In the past year, how many times has the member run away?** _____

**Where does the member go?** _____

**How long are they typically away from home/placement?** _____

| | |
|---|---|
| ☐ **Sexualized behaviors** | **Check all that apply:** ☐ Sexual acting-out ☐ Deviant sexual behavior ☐ Sexual exploitation ☐ Other (describe) _____ |
| ☐ **Psychotic symptoms** | **Check all that apply:** ☐ Auditory hallucinations ☐ Visual hallucinations ☐ Delusions ☐ Other (describe) _____ |

## 10. SUBSTANCE USE INFORMATION

☐ *N/A – PROCEED TO NEXT SECTION*

| TYPE OF SUBSTANCE | ROUTE | FREQUENCY | LAST USE |
|---|---|---|---|
| ☐ **Alcohol** | | | |
| ☐ **Amphetamines** | | | |
| ☐ **Cocaine** | | | |
| ☐ **Hallucinogens** | | | |
| ☐ **Heroin/opiates** | | | |
| ☐ **Inhalants** | | | |
| ☐ **Marijuana** | | | |
| ☐ **Nicotine/e-cigs/JUULs** | | | |
| ☐ **Benzodiazepines/ hypnotics** | | | |
| ☐ **Other** (specify): _____ | | | |

## 11. MEDICAL INFORMATION

| | |
|---|---|
| **Allergies:** | **Drug allergies:** |
| **Special dietary needs:** | |
| **Is the youth up-to-date on CDC-recommended vaccines for their age group?** ☐ Yes ☐ No<br>**Has the youth ever declined or delayed a a CDC-recommended vaccine?** ☐ Yes ☐ No | |
| **Has the youth received vaccination(s) for COVID-19?** ☐ Yes ☐ No<br>**If yes, include the total number of doses received and the dates for the vaccination dose(s), if known:** | |
| **Height of child:** | **Weight of child:** |

### MEDICAL CONDITIONS (PAST AND PRESENT)

**Most recent occurrence:**

| | | |
|---|---|---|
| ☐ Acne | ☐ Anemia | ☐ Asthma |
| ☐ Chronic urinary/bowel problems | ☐ Diabetes | ☐ Eczema/rash |
| ☐ Hepatitis | ☐ HIV/AIDS | ☐ Migraine/headaches |
| ☐ Seizures/epilepsy | ☐ Sexually transmitted infection | ☐ Sickle cell anemia |
| ☐ Thyroid disease | | |

☐ Other: _____ ☐ Other: _____

☐ Other: _____ ☐ Other: _____

**Are there any additional medical concerns or needs?**

## 12. EDUCATIONAL/SCHOOL INFORMATION

| | | |
|---|---|---|
| **Last school enrolled:** | | **Highest grade level completed:** |
| **Is it important the member remain in their current school?** ☐ Yes ☐ No | | |
| **Can the member attend a full day of school?** ☐ Yes ☐ No | | |
| **Does the member have a current IEP?** ☐ Yes ☐ No | **Date:** | **Grade(s) repeated:** |

**Special classes:** ☐ EC ☐ LD ☐ Resource ☐ BED ☐ Homebound ☐ Day Treatment ☐ Other:

**History of suspensions or expulsions?** ☐ Yes ☐ No

**If yes, please explain**:

## 13. LEGAL HISTORY

☐ *N/A – PROCEED TO NEXT SECTION*

| | |
|---|---|
| **Does the member have a criminal record?** ☐ Yes ☐ No | **Is the member on probation?** ☐ Yes ☐ No |

**Are there pending charges?** ☐ Yes ☐ No

**Charge(s) and counties where charge occurred:**

**Briefly describe prior offenses and conviction dates (if known)**:

## 14. DAILY LIVING SKILLS INFORMATION

☐ *N/A – PROCEED TO NEXT SECTION*

(Required ONLY for members with I/DD or co-occurring I/DD and mental health diagnoses.)

### EATING

**Does the member eat solid foods?** ☐ Yes ☐ No *If no, explain:* _____

**Does the member eat independently?** ☐ Yes ☐ No *If no, explain:* _____

**Does the member require special accommodations?** ☐ Yes ☐ No *If yes, explain:* _____

**Is there a history of choking/overfilling mouth?** ☐ Yes ☐ No

### TOILETING

**Is the member continent?** ☐ Yes ☐ No

*If no, indicate brand/size of supplies:* _____

**Can the member use the bathroom alone?** ☐ Yes ☐ No

*If no, explain assistance:* _____

**Does the member wear pull-ups/diapers at night?** ☐ Yes ☐ No

*If yes, indicate brand/size of supplies:* _____

**Will the member tell someone if bathroom is needed?** ☐ Yes ☐ No

**Is the member on a toileting schedule?** ☐ Yes ☐ No

## 14. DAILY LIVING SKILLS INFORMATION - CONTINUED

(Required ONLY for members with I/DD or co-occurring I/DD and mental health diagnoses.)

**SLEEPING**

**Does the member usually sleep through the night?** ☐ Yes ☐ No

**Approximate time member goes to bed:** _____

**List any issues related to sleeping, special equipment needed, etc.:**

**WALKING**

**Is the member ambulatory?** ☐ Yes ☐ No

**If no, does the member use any of the following?** ☐ Walker ☐ Crutches ☐ Wheelchair ☐ Modified shoes

**Does equipment meet current needs?** ☐ Yes ☐ No *If no, explain below:*

**LANGUAGE**

**Is the member verbal?** ☐ Yes ☐ No *If no, complete the questions below:*

**How does the member make their needs known?**

**Does the member understand one- or two-word commands?** ☐ Yes ☐ No

**Does the member follow one/two-step commands?** ☐ Yes ☐ No

**Explain any communication needs (devices, etc.):**

**BEHAVIOR**

**Does the member have a history of any of the following?**

☐ Property destruction ☐ Physical aggression ☐ Verbal aggression

**What does this behavior usually look like?**

**If known, what are triggers for the behavior(s)?**

**Does the member usually hurt themselves or others?** ☐ Yes ☐ No

**Describe any other inappropriate behaviors the member may have:**

## 15. ADDITIONAL INFORMATION

**Provide information related to the member's current status, symptoms, notable improvements/changes, etc., and include any additional comments that may support this application.**

## 16. REFERRAL CHECKLIST

*Please attach any of the following that are available:*

- ☐ Up-to-date person-centered plan and/or Individual Support Plan
- ☐ Inpatient treatment plan
- ☐ Up-to-date CCA/psychiatric assessment/ evaluations/diagnostic assessments
- ☐ Psychological testing
- ☐ Physical assessments/medical information
- ☐ Sexually Aggressive Youth Evaluation/ Sex Offender-Specific Evaluation
- ☐ DSS records
- ☐ DJJ records
- ☐ Court orders
- ☐ Signed Authorization and Consent for Release of Information
- ☐ Other

## 17. SIGNATURES

| | |
|---|---|
| **Legally responsible person printed name** | **Date** |
| **Legally responsible person signature** | **Date** |
| **Member signature** | **Date** |