

Universal Child and Adolescent Residential Placement Application

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

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.)

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

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

If so, with whom, where, and how often?

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

If yes, where?

8. CURRENT SYMPTOMS/OBSERVATIONS

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

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

<input type="checkbox"/> Self-injurious behavior	<p>Check all that apply: <input type="checkbox"/> Cuts on body <input type="checkbox"/> Conceals cutting, <i>indicate area:</i> _____</p> <p><input type="checkbox"/> Other forms of self-injury, <i>Describe:</i> _____</p> <p>Has self-injury ever required medical attention? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Explain:</p>
<input type="checkbox"/> Suicidal characteristics	<p>Check all that apply: <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Past suicide attempts <input type="checkbox"/> Suicidal plans</p> <p>If checked above, describe:</p> <p>_____</p> <p>Describe methods used in previous attempts:</p> <p>_____</p> <p>Were attempts planned? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Unknown</p>
<input type="checkbox"/> Homicidal characteristics	<p>Check all that apply: <input type="checkbox"/> Homicidal thoughts <input type="checkbox"/> Past attempts to harm others</p> <p><input type="checkbox"/> Homicidal plans</p> <p>If checked above, describe:</p> <p>_____</p> <p>Describe methods used in previous attempts:</p> <p>_____</p> <p>Were attempts planned? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Unknown</p> <p>Does the member have access to weapons? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Explain:</p>
<input type="checkbox"/> History of elopement	<p>Check all that apply: <input type="checkbox"/> Runs away from home <input type="checkbox"/> Has run from previous placements</p> <p>In the past year, how many times has the member run away? _____</p> <p>Where does the member go? _____</p> <p>How long are they typically away from home/placement? _____</p>
<input type="checkbox"/> Sexualized behaviors	<p>Check all that apply: <input type="checkbox"/> Sexual acting-out <input type="checkbox"/> Deviant sexual behavior <input type="checkbox"/> Sexual exploitation</p> <p><input type="checkbox"/> Other (describe) _____</p>
<input type="checkbox"/> Psychotic symptoms	<p>Check all that apply: <input type="checkbox"/> Auditory hallucinations <input type="checkbox"/> Visual hallucinations <input type="checkbox"/> Delusions</p> <p><input type="checkbox"/> Other (describe) _____</p>

10. SUBSTANCE USE INFORMATION

☐ N/A – PROCEED TO NEXT SECTION

TYPE OF SUBSTANCE	ROUTE	FREQUENCY	LAST USE
<input type="checkbox"/> Alcohol			
<input type="checkbox"/> Amphetamines			
<input type="checkbox"/> Cocaine			
<input type="checkbox"/> Hallucinogens			
<input type="checkbox"/> Heroin/opiates			
<input type="checkbox"/> Inhalants			
<input type="checkbox"/> Marijuana			
<input type="checkbox"/> Nicotine/e-cigs/JUULs			
<input type="checkbox"/> Benzodiazepines/ hypnotics			
<input type="checkbox"/> Other (specify):			

11. MEDICAL INFORMATION

Allergies:

Drug allergies:

Special dietary needs:

Immunization status: ☐ Current ☐ Delayed ☐ Refused

MEDICAL CONDITIONS (PAST AND PRESENT)

Most recent occurrence:

<input type="checkbox"/> Acne	<input type="checkbox"/> Anemia	<input type="checkbox"/> Asthma
<input type="checkbox"/> Chronic urinary/bowel problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Eczema/rash
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Migraine/headaches
<input type="checkbox"/> Seizures/epilepsy	<input type="checkbox"/> Sexually transmitted infection	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> Thyroid disease		
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Other: _____	<input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Can the member attend a full day of school? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Does the member have a current IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date:	Grade(s) repeated:
Special classes: <input type="checkbox"/> EC <input type="checkbox"/> LD <input type="checkbox"/> Resource <input type="checkbox"/> BED <input type="checkbox"/> Homebound <input type="checkbox"/> Other:			
History of suspensions or expulsions? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please explain:			

13. LEGAL HISTORY

☐ N/A – PROCEED TO NEXT SECTION

Does the member have a criminal record? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the member on probation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are there pending charges? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Charge(s) and counties where charge occurred:	
Briefly describe prior offenses and conviction dates (if known):	

14. DAILY LIVING SKILLS INFORMATION

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

EATING

Does the member eat solid foods?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, explain: _____
Does the member eat independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If no, explain: _____
Does the member require special accommodations?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, explain: _____
Is there a history of choking/overfilling mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

TOILETING

Is the member continent?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, indicate brand/size of supplies: _____	
Can the member use the bathroom alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, explain assistance: _____	
Does the member wear pull-ups/diapers at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, indicate brand/size of supplies: _____	
Will the member tell someone if bathroom is needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is the member on a toileting schedule?	<input type="checkbox"/> Yes <input type="checkbox"/> 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:

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

17. SIGNATURES

Legally responsible person printed name

Date

Legally responsible person signature

Date

Member signature

Date