Universal Residential Treatment Application

Date of Application: _____ **Date of Service Needed:** _____

Type of referral Needed/CFT Recommendation:

☐ Residential Treatment Level 2
☐ Residential Treatment Level 3
☐ Psychiatric Residential Treatment Facility

Section I: Consumer Information

Consumer's Name: _____ Nickname: _____
Social Security Number: _____ Date of Birth:_____Age:_____ Sex:_____
Medicaid Number**:**_____ County: _____Weight:_____ Height:_____
Consumer's Current Address:_____
Consumer's Phone Number: _____Current Living Arrangement :_____
Place of Birth:_____Primary Language: _____
Distinguishing Features (i.e., scars, tattoos, birthmarks, etc.): _____
_____

Section II: Guardian Information

Legal Guardian: _____
Relationship: _____ County of Legal Custody: _____
Guardian's Address: _____
Guardian's Phone Number: _____ Cell:_____
If a Guardian ad Litem has Been Appointed Please List Name and Contact Number:
_____

Section III: Consumer Primary Referral Source Information:

Referring Agency: Support ☐ DJJ ☐ DSS ☐ County: _____
Other: _____
Provider Agency: _____ Phone #: _____
Agency Contact Person: _____ Phone #: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Emergency Contact: _____ Relationship to Consumer: _____
Contact #: _____ Fax#: _____ Pager/Cell#: _____
Address: _____

Section IV: Clinical/Diagnostic Information:

DSM IV-TR Multi-Axial Diagnosis

Diagnoses:	Effective Date:	Source:
Axis I:_____,_____,_____,_____		
Axis II:		
Axis III:		
Axis IV: _____ _____ _____		
Axis V:		

CALOCUS Score: _____

IQ: _____ Verbal: _____ Performance: _____ Full Scale: _____

Examiner: _____ Date: _____

History of Abuse

☐ Victim of Neglect: _____

☐ Victim of Physical Abuse: _____

☐ Victim of Sexual Abuse: _____

☐ Victim of Emotional Abuse: _____

☐ None

If checked please provide a written description. If DSS involvement please attach documentation.

Medications	Prescribing Physician	Dosage/Frequency	Date Started / Compliant

Section V: Medical Information

Allergies: _____

Special Dietary Needs: _____

Medical Conditions (past and present): *Please note most recent occurrence*

☐ **Lice**	☐ **Bulimia**	☐ **Eczema**
☐ **Anemia**	☐ **Anorexia**	☐ **Asthma**
☐ **Drug/Alcohol Abuse**	☐ **Measles**	☐ **Hay Fever**
☐ **HIV/AIDS**	☐ **Mumps**	☐ **Convulsions**
☐ **Sexually Transmitted Disease**	☐ **Chicken Pox**	☐ **Sinus Problems**
☐ **Ringworm**	☐ **Sickle Cell Anemia**	☐ **Diabetes**
☐ **Tuberculosis**	☐ **Migraine Headaches**	☐ **Hepatitis**
☐ **Chronic Urinary/Bowel Problems**	☐ **Rubella**	☐ **TBI**

Other: _____ Other: _____ Other: _____

Name and Address of Pediatrician: _____

Name and Address of Dentist: _____

Date of Last Phys. Exam: _____ Last Dental Exam:_____ Last Eye Exam: _____

Dental Appliances: ☐ Yes ☐ No Contacts/Glasses: ☐ Yes ☐ No

Medical Insurance Company: ☐ Medicaid_____ ☐ NC Health Choice _____

Private Ins.(Agency): _____

Insurance Policy Number: _____

Insurance is in Whose Name? _____

Any Other Third Party Insurance? _____

Section VI: Strengths/Abilities/Preferences

Strengths/Capabilities: _____
_____
_____
_____

Friendships/Social/Peer Support: _____
_____
_____

Religion/Spirituality: _____
_____

Cultural/Ethnic Concerns: _____
_____
_____

Meaningful Activities (community involvement, volunteer activities, leisure recreation, other interests):
_____
_____
_____

Goals for Independent Living: _____
_____
_____

Section VII: Presenting Problems/Concerns, Reason for Referral (specify)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Section VIII: Previous Treatment Interventions

Outpatient	Date	Effectiveness

Section IX: Placement History

Placement (Begin w/Current Placement)	Dates (From – To)	Reason for Discharge

Section X: Current Emotional/Behavioral Problems

Please describe behavior and date of the last incident.

☐ Abandonment Issues	☐ Anxiety	☐ Arson
☐ Alcohol/Drug Abuse	☐ Antisocial Behavior	☐ Stool/Feces smearing
☐ Assaultive (Physical)	☐ Assaultive (Sexual)	☐ Assaultive (Verbal)
☐ Bedwetting	☐ Eating Disorder	☐ Depression
☐ Property Destroying	☐ Fire Setter	☐ Developmental Disability
☐ Homeless	☐ Hyperactive	☐ Impulsive
☐ Lying	☐ Low Self-Esteem	☐ Loss/Grief Difficulties
☐ Physical Impairment	☐ Mental Retardation	☐ Parent Neglect Issues
☐ Perception of Reality	☐ Phobic Behavior	☐ Physical Disability
☐ Self-Destructive Behavior	☐ Sibling Related Difficulty	☐ Oppositional
☐ Social Immaturity	☐ Sexually Inappropriate Behavior	☐ Stealing
☐ Suicidal	☐ Running Away	☐ Truancy
☐ Unruly/Ungovernable	☐ Cruelty to Animals	☐ Hygiene/Cleanliness Issues
☐ Problems with Sleep	☐ Gang Related Activity	☐ History w/ Weapons

Other: _____

Aggressive or Violent Behavior Alert

Please describe the nature of the acting out behaviors:

☐ Verbally Aggressive, Frequency: _____

Description: _____
_____
_____

☐ Physically Aggressive, Frequency: _____

Description: _____
_____
_____

☐ Property Destruction, Frequency: _____

Description: _____
_____
_____

Has the Behavior Resulted in Injury to Others? ☐ Criminal Charges? Please describe:
_____
_____
_____
_____

Aggression is: ☐ Impulsive ☐ Planned ☐ Instrumental ☐ Triggered by Fearfulness

Where is the Client Aggressive:
_____
_____

Known Triggers, Please Describe:
_____
_____

Main Targets of Aggression: ☐ Peers ☐ Authority Figures ☐ Family Members (Please be specific)
_____
_____
_____
_____

Please Describe the Most Recent Episode of Aggression
_____
_____
_____
_____
_____
_____

History of Self-Injurious/ Risky Behaviors

Self-Injury	**Check all that apply:** ☐ Cuts on Body ☐ Conceals Cutting- Indicated Area ☐ Other Forms of Self-Injury (please describe): _____ Has Self-Injury ever Required Medical Attention? ☐ Yes ☐ No (Please explain): _____
Suicidal Characteristics	**Check all that apply:** ☐ Suicidal Thoughts ☐ Past Suicide Attempts ☐ Suicidal Plans (describe): _____ Methods Used in Previous Attempts (describe): _____ Were Attempts Planned: ☐ Yes ☐ No ☐ Sometimes ☐ Don't know
Homicidal Characteristics	**Check all that apply:** ☐ Homicidal Thoughts ☐ Past Attempts to Harm Others ☐ Homicidal Plans (describe): _____ Methods Used in Previous Attempts (please describe): _____ Were Attempts Planned: ☐ Yes ☐ No ☐ Sometimes ☐ Don't know Does Consumer have Access to Weapons? ☐ Yes ☐ No Please Explain: _____
History of AWOL	Runs Away from Home: ☐ Yes ☐ No Has Run from Previous Placements: ☐ Yes ☐ No In the Past Year how Many Times has Consumer Run? _____ Where Does He/She Go? _____ How Long is Consumer Typically AWOL? _____
Substance Abuse History	**Check all that apply:** ☐ Marijuana Frequency: _____- Last Used: _____ ☐ Cocaine Frequency: _____ -Last Used: _____ ☐ Heroin/Opiates Frequency: _____- Last Used: _____ ☐ Amphetamines Frequency: _____- Last Used: _____ ☐ Inhalants Frequency: _____- Last Used: _____ ☐ Hallucinogens Frequency: _____- Last Used: _____ ☐ Alcohol Frequency: _____- Last Used: _____ ☐ Other: Frequency: _____- Last Used: _____ Explain: _____
Sexual Behaviors	Describe any Sexualized Behaviors Exhibited by Consumer (i.e. peeping, sexual acting out, predatory behaviors, prostitution): _____ _____ _____ _____
Psychotic Behaviors	Please Describe any Past/Present History of Psychosis: _____ _____ _____ _____

Section XI: Family Information

Biological Mother's Name: _____

Address: _____

Telephone Number: Home: _____Work:_____Cell:_____

Ethnicity: _____ Education Level: _____ (Unknown ☐)

Criminal Record: ☐Yes ☐No ☐Unknown

Biological Father's Name: _____

Address: _____

Telephone Number: Home: _____ Work: Cell: _____

Ethnicity: _____ Education Level: _____ (Unknown ☐)

Criminal Record: ☐Yes ☐No ☐Unknown

Check all that apply:
Are Parents: ☐ Married ☐Separated ☐ Divorced ☐Never Married ☐Deceased Mother ☐Deceased Father

Have Parental Rights Been Terminated: ☐Yes ☐No

If so, Who and When?

_____

_____

Siblings:

Name	Age	Gender

Are Siblings in Out-of-Home Placements? ☐ Yes ☐ No

If yes, please specify: ☐ DSS Foster Care ☐ Relatives ☐ Incarcerated ☐ Group Home ☐ Other:

Explain: _____

Section XII: Family Social History

Include description of social history, and significant family events leading up to referral, and living arrangement prior to referral. If checked please explain.

☐ Criminal Activity	☐ Child Abuse
☐ Inappropriate Sexual Behavior	☐ Treatment Disruption
☐ Psychiatric Illness	☐ Substance Abuse
☐ Suicide	☐ Other:

_____
_____
_____
_____
_____
_____

If other pertinent family history please document separately and attach.

Section XIII: Authorized Contacts/Resources

Name	Relationship	Address	Telephone Number	Types of Contact (supervised, letter, etc.)	Date of Release of Information

Special Conditions/Restrictions for HomeVisits?_____
_____
_____
_____
_____

Section XIV: School Information

Last School Enrolled: _____ District: _____

Grade: _____ Special Classes: ☐EH ☐LD ☐Resource ☐BEH ☐Homebound ☐Other: _____

Any History of Truancy? ☐ Yes ☐ No Grade(s) Repeated: _____ Current IEP? ☐ Yes ☐ No

Suspensions/Expulsions: _____

Section XV: Agency/Provider Involvement

Indicate all agencies currently involved:

☐ DSS_____ ☐ Mental Health Provider _____ ☐ DJJ_____

☐ Vocational Rehabilitation_____ ☐ Other: _____

Section XVI: Court History

Does Consumer Have a Criminal Record? ☐ Yes ☐ No

Offenses	Conviction Dates	Tried as Juvenile or Adult

Pending Charges: _____

Is Consumer on Probation? ☐ Yes ☐ No Name and Contact: _____

Is Placement Court Ordered? ☐ Yes ☐ No **(If "Yes, attach court order)**

Section XVII: Final Comments

Estimated Length of Stay: ☐ 90 Days ☐ 180 Days ☐ 270 Days ☐ 360 Days

Check All That Apply

Anticipated Discharge Plan: ☐ Return Home ☐ Step Down Placement ☐ Community Supports

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signatures:

Legal Guardian	**Print Name**	**Date**
Social Worker	**Print Name**	**Date**
Case Manager	**Print Name**	**Date**
CC/DJJ	**Print Name**	**Date**
Care Coordinator	**Print Name**	**Date**