**RESIDENTIAL SERVICES APPLICATION**

Date Completed:

Date Needed:

Service Needed: Residential Level 2 Residential Level 3

**CONSUMER INFORMATION**

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| Consumer’s Name:  Nickname:  Social Security Number:  Date of Birth:  Age:  Sex: Male Female Transgender  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.): |

**GUARDIAN INFORMATION**

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| Legal Guardian:  Relationship:  County of Legal Custody:  Guardian’s Address:  Guardian’s Phone Number:  Guardian Ad Litem: Yes  NoIf yes, name and number: |

**CONSUMER’S PRIMARY REFERRAL SOURCE INFORMATION**

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| Referring Agency:  Provider  MCO  DJJ DSS/YFS  Other:  Provider Agency:  Agency Contact Person:  Telephone:  Address:  City/State/Zipcode:  Emergency Contact Person:  Relationship to Consumer:  Telephone:  Address: |

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| Diagnosis: | Date: | Source: |
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| DSM 5 Diagnosis  CALOCUS Score:  IQ Examiner & Date:   |  |  |  |  |  | | --- | --- | --- | --- | --- | | Full Scale | Processing Speed | Working Memory | Perceptual Reasoning | Verbal Comprehension | |  |  |  |  |  |   Trauma History:  Victim of Neglect ­Victim of Physical Abuse Victim of Sexual Abuse Victim of Emotional Abuse None  If checked please provide a written description:  Current Medications:   |  |  |  |  | | --- | --- | --- | --- | | Medications | Prescribing Physician | Dosage/Frequency | Date Started / Compliant? | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |

**CLINICAL/DIAGNOSTIC INFORMATION**

**MEDICAL INFORMATION**

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| Allergies:  Special Dietary Needs:  Please check for any of the following medical conditions & note when if possible.  Anemia Anorexia Asthma  Bulimia Chicken Pox Chronic Urinary/Bowel problems  Diabetes Drug/Alcohol Abuse Eczema  GERD/Acid Reflux Hay Fever Hepatitis  HIV/AIDS Lice Measles  Migraine Headaches Mumps Ringworm  Rubella Seizures/Convulsions Sexually Transmitted Disease  Sickle Cell Anemia Sinus Problems Traumatic Brain Injury  Tuberculosis  Other \_\_\_\_\_\_\_\_\_\_\_  Name and Address of Pediatrician:  Name and Address of Dentist:  Date of Last Phys. Exam:  Date of Last Dental Exam:  Date of Last Eye Exam:  Dental Appliances: Yes No  Contacts/Glasses: Yes No  Medical Insurance Company: Medicaid  NC Health Choice  Private Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Private Insurance Policy Number:  Private Insurance is in whose name?  Any other third party insurance? |

**STRENGTHS/ABILITIES/PREFERENCES**

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| Strength/Capabilities:  Friendships/Social/Peer Support Relationships:  Religion/Spirituality:  Cultural/Ethnic Issues/Information/Concerns:  Meaningful Activities (community involvement, volunteer activities, leisure recreation, other interests):  Goals for Independent Living: |

**PREVIOUS TREATMENT INTERVENTIONS**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| **Child Service Dates Provider Comments (Treatment Outcome)**   |  |  |  |  | | --- | --- | --- | --- | | Outpatient Treatment |  |  |  | | Inpatient Hospitalization |  |  |  | | Adolescent SA Outpatient |  |  |  | | Adolescent SA Residential |  |  |  | | Residential Services |  |  |  | | Intensive In Home |  |  |  | | MST |  |  |  | | Other |  |  |  | |

**PRESENTING PROBLEMS / REASON FOR REFERRAL**

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**CURRENT EMOTIONAL / BEHAVIORAL PROBLEMS**

(Please describe the behaviors within the last 30-45 days)

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| 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 |
| Intellectual Disability | Low Self-Esteem | Lying |
| Loss/Grief Difficulties | Physical Impairment | 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 |

**AGGRESSIVE OR VIOLENT BEHAVIOR:**

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| Verbally aggressive: Yes  No  How often?  Describe (in detail what this looks like):  Physically aggressive:  Yes  No  How often?  Describe (in detail what this looks like):  Property Damage: Yes  No  How often?  Describe (in detail what this looks like):  Has the behavior resulted in injury to others?Yes  No  Describe (in detail what this looks like):  Any criminal charges? Yes  No  Please describe:  Aggression is: impulsive  planned instrumental  triggered by fearfulness  Main targets of aggression:  peers  authority figures  family Consumers  Where is Consumer aggressive?  home  school  community  Describe any known triggers:  Please describe the most recent episode of aggression: |

**FAMILY INFORMATION:**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Has Consumer been adopted?  Yes  No If so, then when and by whom?  Are Parents: Married Separated Divorced Never Married  Deceased Mother Deceased Father Unknown  Have Parental Rights been terminated? Yes  No If so, then who and when:  Have Parental Rights been relinquished?  Yes  If so, then who and when:  Mother’s Name:  Address:  Telephone Number:  Ethnicity:  Education Level:  Criminal Record: Yes  No  Unknown  Father’s Name:  Address:  Telephone Number:  Ethnicity:  Education Level:  Criminal Record: Yes  No  Unknown  How many siblings does Consumer have?   |  |  |  | | --- | --- | --- | | Age | Gender | Name | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  |   Are siblings in out of home placements? Yes  No  Unknown  If yes, please indicate where: DSS Foster Care Relatives Incarcerated Group Home Other: |

**FAMILY DYNAMICS / 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 | |

**AUTHORIZED CONTACTS**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Name | Relationship | Address | Telephone Number | Types of Contact  With Consumer  (supervised, letter, etc.) | Date of Release of Information | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  | |  |  |  |  |  |  |   Are there any special conditions/restrictions for visits home?  Any “no contact” orders? |

**AGENCY INVOLVEMENT**

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| DSS County:  DJJ County:  Advocacy Agency:  Mental Health Provider:  MCO: |

**SCHOOL INFORMATION**

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| --- |
| Last School Enrolled:  District:  Last Grade Enrolled:  K  1  2  3  4  5  6  7  8  9  10  11  12  Current IEP?  Yes  No Date:  Current 504 plan?  Yes  No Date:  IEP Classification:  Unknown  Autism  Emotional Disturbance  Hearing Impairment  Blindness  Deafness  Orthopedic Impairment  Specific Learning Disability  Multiple Disabilities  Visual Impairment  Speech/Language Impairment  Traumatic Brain Injury Developmental Delay  Other Health Impairment (Specify): ­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Any history of truancy?  Yes  No  Unknown  Grades Repeated:  Suspensions/Expulsions: Yes  No Please describe reasons for suspensions & provide dates of most current: |

**COURT HISTORY**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Does Consumer have a criminal record?  Yes  No   |  |  |  | | --- | --- | --- | | Offenses | Conviction Dates | Juvenile or Adult? | |  |  |  | |  |  |  | |  |  |  | |  |  |  |   Pending Charges?  Yes  No If yes, please list:  On probation? Yes  No   * Probation Officer/ Court Counselor Name: * Contact Number: * Probation Restrictions:   Is placement court ordered?  Yes  No (If “Yes, attach court order) |

**HISTORY OF SELF-INJURY AND RISK BEHAVIORS**

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| Self-Injury:   * Does not apply * cuts on body  conceals cutting other: * Has self-injury ever required medical attention? Please explain:   Suicidal Characteristics:   * Does not apply * Suicidal thoughts  Past Suicide Attempts  Suicidal Plans * Describe: * Any method used in attempt? Please list: * Were attempts planned:  yes  no  sometimes  don’t know   Homicidal Characteristics:   * Does not apply * homicidal thoughts  Past Attempts to harm others  Homicidal Plans * Describe: * Any method used in attempt? Please list: * Were attempts planned:  yes  no  sometimes  don’t know * Does Consumer have access to weapons? Please explain   History of AWOL:   * Does not apply * Runs away from home  Has run from previous placements * In the past year how many times has Consumer run? * Where does he/she go? * How long is he/she typically AWOL?   Substance Abuse History:   * Does not apply * See below:  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Type of Substance | Frequency | Last Use | Type of Substance | Frequency | Last Use | | Marijuana |  |  | Amphetamines |  |  | | Cocaine |  |  | Hallucinogens |  |  | | Heroin/Opiates |  |  | Alcohol |  |  | | Inhalants |  |  | Other: |  |  |   Sexualized Behaviors:   * Does not apply * Please describe any sexualized behaviors exhibited by Consumer (i.e. exposure, sexual acting out, predatory behaviors, prostitution)   Psychotic Behaviors:   * Does not apply * Please describe any past/present history of psychosis: |

**ADDITIONAL COMMENTS**

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| Please use this space to include any additional comments that may support this application. |

**SUPPORTING REFERRAL DOCUMENTS**

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| The following are items that may be needed in support of this packet or for placement. Please be prepared to submit these with the application or as needed at a provider’s request.  Universal Application  Person Centered Plan/Sign Page  Discharge Summaries from Hospitalizations/ Previous Treatment  Consent to exchange information  School Records/ IEP  DSS records (if applicable)  DJJ records (if applicable)  Psychological Testing  Sexual Harm Youth Evaluation  Psychological Testing  Immunization Records  Birth Certificate  Copy of Medicaid/ Insurance Cards  Psychiatric evaluations  Diagnostic Assessment ( or any other assessment completed)  Treatment Authorization Request  Court/Custody Orders |

**SIGNATURES**

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Consumer Signature Date

*(Please note if this application includes information about substance use, the Consumer’s signature must be obtained)*

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Legal Guardian Signature Date

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Provider/Clinician/Care Coordinator Signature Date