**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 [ ] TransgenderMedicaid 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**

|  |
| --- |
| 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 DiagnosisCALOCUS 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 [ ] NoneIf checked please provide a written description: Current Medications:

|  |  |  |  |
| --- | --- | --- | --- |
| Medications | Prescribing Physician | Dosage/Frequency | Date Started / Compliant? |
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 **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 [ ] NoMedical 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**

|  |
| --- |
| 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  |  |  |  |

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**PRESENTING PROBLEMS / REASON FOR REFERRAL**

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|  |

**CURRENT EMOTIONAL / BEHAVIORAL PROBLEMS**

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

|  |  |  |
| --- | --- | --- |
| [ ] 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:**

|  |
| --- |
| 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 ConsumersWhere 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 |
|  |  |  |
|  |  |  |
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Are siblings in out of home placements? [ ] Yes [ ]  No [ ]  UnknownIf 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  |

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**AUTHORIZED CONTACTS**

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

**AGENCY INVOLVEMENT**

|  |
| --- |
| [ ]  DSS County: [ ]  DJJ County: [ ]  Advocacy Agency: [ ]  Mental Health Provider:[ ]  MCO:  |

**SCHOOL INFORMATION**

|  |
| --- |
| Last School Enrolled: District: Last Grade Enrolled: [ ]  K [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5 [ ]  6 [ ]  7 [ ]  8 [ ]  9 [ ]  10 [ ]  11 [ ]  12Current 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**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Does Consumer have a criminal record? [ ]  Yes [ ]  No

|  |  |  |
| --- | --- | --- |
| Offenses | Conviction Dates  | Juvenile or Adult?  |
|  |  |  |
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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**

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

**SUPPORTING REFERRAL DOCUMENTS**

|  |
| --- |
| 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 ApplicationPerson Centered Plan/Sign Page Discharge Summaries from Hospitalizations/ Previous Treatment Consent to exchange informationSchool Records/ IEPDSS records (if applicable) DJJ records (if applicable)Psychological TestingSexual Harm Youth EvaluationPsychological TestingImmunization RecordsBirth Certificate Copy of Medicaid/ Insurance CardsPsychiatric evaluationsDiagnostic Assessment ( or any other assessment completed) Treatment Authorization RequestCourt/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

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider/Clinician/Care Coordinator Signature Date