**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.

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| **Date referral form completed:** | Enter date. | **Date service needed:** | Enter date. |
| **Type of referral/Level of Care sought** |
| [ ]  Residential Level I – Family type[ ]  Residential Level II – Family type[ ]  Residential Level II – Program type[ ]  Residential Level Ill – Group home[ ]  Residential Level IV – Secure[ ]  Psychiatric Residential Treatment Facility (PRTF)[ ]  Emergent Need Respite – internal referrals only[ ]  Residential Supports, Alternative Family Living (AFL) – NC Innovations Waiver | [ ]  Residential Supports, Group home – NC Innovations Waiver[ ]  Non-Medicaid-Funded Residential Services – Group home or AFL[ ]  Long-Term Community Supports – intellectual/developmental disability (I/DD) residential services (Medicaid)[ ]  Individual Supports – Mental health (Medicaid)[ ]  Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) |
| **Member name:** | Click or tap here to enter text. |
| **Is the member a Medicaid beneficiary?** | [ ]  Yes | [ ]  No | **If yes, Medicaid ID#:** | Click or tap here to enter text. |
| **LME/MCO or PHP benefit plan:** | Click or tap here to enter text. |
| **Does the member have a CCA?** | [ ]  Yes | [ ]  No | **If yes, date of most recent CCA:** | Enter date |
| *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: | Enter text |  |
|  | [ ]  Other: | Click or tap here to enter text. |  |
|  |
| **Name of referring agency:** | Click or tap here to enter text. |
| **Contact person:** | Click or tap here to enter text. | **Phone number:** | Click or tap here to enter text. |
| **Alternate contact number:** | Click or tap here to enter text. | **Fax number:** | Click or tap here to enter text. |
| **Reason for referral:** Click or tap here to enter text. |
| **2. MEMBER DEMOGRAPHIC INFORMATION** |
| **Member name:** | Enter name | **Preferred name:** | Click or tap here to enter text. |
| **Date of birth:** | Enter date | **Age:** | Age | **Gender assigned at birth:** | [ ]  Male | [ ]  Female |
| **Gender identity:** | Choose an item. | **Pronouns:** | Choose an item. | **Sexual orientation:** | Enter text. |
| **Race:** | Click or tap here to enter text. | **Place of birth:** | Click or tap here to enter text. |
| **Primary language:** | Enter text. | **Does the member speak English?** | [ ]  Yes | [ ]  No |
| **County from which Medicaid originates:** | Click or tap here to enter text. |
| **What counties are you open to placement in?** | [ ]  Any | [ ]  Specific counties (please list below) |
| Click or tap here to enter text. |
| **Current living arrangement:** | Click or tap here to enter text. |
| **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.)*Click or tap here to enter text.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**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):**Click or tap here to enter text. |
| **3. LEGALLY RESPONSIBLE PERSON INFORMATION** |
| **Who is legally responsible for the child?** | [ ]  Parent | [ ]  Guardian | [ ]  County DSS | [ ]  Other |
| **Name of guardian/custodian:** | Click or tap here to enter text. | **Relationship to member:** | Enter text. |
| **If in DSS custody, county of legal custody:** | Enter text. | **Permanency plan:** | Click or tap here to enter text. |
| **Has there been a termination of parental rights?** | [ ]  Yes | [ ]  No |
| **If yes, date and by whom:** | Click or tap here to enter text. |
| **Home phone:** | Home phone | **Work phone:** | Work phone | **Mobile phone:** | Mobile phone |
| **Mailing address:** | Click or tap here to enter text. | **Email:** | Click or tap here to enter text. |
| **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?** Click or tap here to enter text.  |
| **Are there religious, spiritual, or cultural considerations?** Click or tap here to enter text.  |
| **Are there existing visitations?** | [ ]  Yes | [ ]  No |
| **Are the visits supervised?** | [ ]  Yes | [ ]  No |
| **If yes, by who?** Click or tap here to enter text. |
| **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.)*Click or tap here to enter text. |
| **Does the member have siblings?** | [ ]  Yes | [ ]  No |
| **If yes, list their first names:** Click or tap here to enter text. |
| **Are you seeking placement of the siblings together?** | [ ]  Yes | [ ]  No |
| **If yes, which siblings?** Click or tap here to enter text. |
| **5. CLINICAL/DIAGNOSTIC INFORMATION** |
| **DSM-5 – DIAGNOSTIC INFORMATION** |
| **CODE** | **DIAGNOSIS** |
| Enter code | Click or tap here to enter text. |
| Enter code | Click or tap here to enter text. |
| Enter code | Click or tap here to enter text. |
| Enter code | Click or tap here to enter text. |
| Enter code | Click or tap here to enter text. |
| Enter code | Click or tap here to enter text. |
| **Primary diagnosis:** | Click or tap here to enter text. | **Secondary diagnosis:** | Click or tap here to enter text. |
| **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** |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. |
| **7. TREATMENT AND PLACEMENT HISTORY** |
| **Number of out-of-home placements:** | Click or tap here to enter text. |
| **Has the member been hospitalized?** | [ ]  Yes | [ ]  No | **If yes, how many times in the past year?** | Enter text. |
| **Has the member been in residential placement in the past year?** | [ ]  Yes | [ ]  No |
| **If yes, where?** Click or tap here to enter text. |
| **Has the member had a psychosexual evaluation?** | [ ]  Yes | [ ]  No |
| **If yes, date of most recent:** Click or tap here to enter text. |
| **Has the member had a trauma evaluation?** | [ ]  Yes | [ ]  No |
| **If yes,** **date of most recent:** Click or tap here to enter text. |
| **Has the member received trauma treatment?** | [ ]  Yes | [ ]  No |
| **Describe:** Click or tap here to enter text. |
| **8. CURRENT SYMPTOMS/OBSERVATIONS** |
| **Check all that apply. Provide specific details and/or the date of last incident, if known and applicable.** |
| [ ]  Abandonment issuesClick or tap here to enter text. | [ ]  AnxietyClick or tap here to enter text. | [ ]  Difficulties at schoolClick or tap here to enter text. |
| [ ]  Stool/feces smearingClick or tap here to enter text. | [ ]  Sexually inappropriate behaviorClick or tap here to enter text. | [ ]  Fire-starting/arsonClick or tap here to enter text. |
| [ ]  BedwettingClick or tap here to enter text. | [ ]  Eating disorder behaviorsClick or tap here to enter text. | [ ]  Problems with sleepClick or tap here to enter text. |
| [ ]  Property destructionClick or tap here to enter text. | [ ]  HomelessnessClick or tap here to enter text. | [ ]  HyperactivityClick or tap here to enter text. |
| [ ]  ImpulsivityClick or tap here to enter text. | [ ]  LyingClick or tap here to enter text. | [ ]  Low self-esteemClick or tap here to enter text. |
| [ ]  Loss/griefClick or tap here to enter text. | [ ]  PhobiasClick or tap here to enter text. | [ ]  Sibling-related difficultyClick or tap here to enter text. |
| [ ]  OppositionalClick or tap here to enter text. | [ ]  Social immaturityClick or tap here to enter text. | [ ]  StealingClick or tap here to enter text. |
| [ ]  TruancyClick or tap here to enter text. | [ ]  Cruelty to animalsClick or tap here to enter text. | [ ]  Hygiene/cleanliness issuesClick or tap here to enter text. |
| [ ]  Hygiene/cleanliness issuesClick or tap here to enter text. | [ ]  Gang-related activityClick or tap here to enter text. | [ ]  History with weaponsClick or tap here to enter text. |
| **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:** Click or tap here to enter text. |
| **9. RISK ASSESSMENT** |
| [ ]  **Self-injurious behavior** |

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| **Check all that apply:** | [ ]  Cuts on body | [ ]  Conceals cutting, *indicate area:* | Enter text |
| [ ]  Other forms of self-injury, *Describe:* | Click or tap here to enter text. |
| **Has self-injury ever required medical attention?** | [ ]  Yes | [ ]  No |
| **Explain:** Click or tap here to enter text.  |

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| [ ]  **Suicidal characteristics** |

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| **Check all that apply:** | [ ]  Suicidal thoughts | [ ]  Past suicide attempts | [ ]  Suicidal plans |
| **If checked above, describe:** Click or tap here to enter text.  |
| **Describe methods used in previous attempts:** Click or tap here to enter text.  |
| **Were attempts planned?** | [ ]  Yes | [ ]  No | [ ]  Sometimes | [ ]  Unknown |

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| [ ]  **Homicidal characteristics** |

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| **Check all that apply:** | [ ]  Homicidal thoughts | [ ]  Past attempts to harm others |
|  | [ ]  Homicidal plans |  |
| **If checked above, describe:** Click or tap here to enter text.  |
| **Describe methods used in previous attempts:** Click or tap here to enter text.  |
| **Were attempts planned?** | [ ]  Yes | [ ]  No | [ ]  Sometimes | [ ]  Unknown |
| **Does the member have access to weapons?** | [ ]  Yes | [ ]  No |
| **Explain:** Click or tap here to enter text. |

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| [ ]  **History of elopement** |

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| **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?** | Click or tap here to enter text. |
| **Where does the member go?** | Click or tap here to enter text. |
| **How long are they typically away from home/placement?** | Click or tap here to enter text. |

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| [ ]  **Sexualized behaviors** |

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| **Check all that apply:** | [ ]  Sexual acting-out | [ ]  Deviant sexual behavior | [ ]  Sexual exploitation |
| [ ]  Other (describe) | Click or tap here to enter text. |

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| [ ]  **Psychotic symptoms** |

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| **Check all that apply:** | [ ]  Auditory hallucinations | [ ]  Visual hallucinations | [ ]  Delusions |
| [ ]  Other (describe) | Click or tap here to enter text. |

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| **10. SUBSTANCE USE INFORMATION** | [ ]  *N/A – PROCEED TO NEXT SECTION* |
| **TYPE OF SUBSTANCE** | **ROUTE** | **FREQUENCY** | **LAST USE** |
| [ ]  **Alcohol** | Enter route | Enter frequency | Enter last use |
| [ ]  **Amphetamines** | Enter route | Enter frequency | Enter last use |
| [ ]  **Cocaine** | Enter route | Enter frequency | Enter last use |
| [ ]  **Hallucinogens** | Enter route | Enter frequency | Enter last use |
| [ ]  **Heroin/opiates** | Enter route | Enter frequency | Enter last use |
| [ ]  **Inhalants** | Enter route | Enter frequency | Enter last use |
| [ ]  **Marijuana** | Enter route | Enter frequency | Enter last use. |
| [ ]  **Nicotine/e-cigs/JUULs** | Enter route | Enter frequency | Enter last use |
| [ ]  **Benzodiazepines/ hypnotics** | Enter route | Enter frequency | Enter last use |
| [ ]  | **Other** (specify):Enter text | Enter route | Enter frequency | Enter last use |
| **11. MEDICAL INFORMATION** |
| **Allergies:** | Click or tap here to enter text. | **Drug allergies:** | Click or tap here to enter text. |
| **Special dietary needs:** | Click or tap here to enter text. |
| **Is the youth up-to-date on CDC-recommended vaccines for their age group?** [ ]  Yes [ ]  No**Has the youth ever declined or delayed a CDC-recommended vaccine?** [ ]  Yes [ ]  No |
| **Has the youth received vaccination(s) for COVID-19?** | [ ]  Yes | [ ]  No |
| **If yes, include the total number of doses received and the dates for the vaccination dose(s), if known:**Click or tap here to enter text. |
| **Height of child:** Click or tap here to enter text. | **Weight of child:** Click or tap here to enter text. |
| **MEDICAL CONDITIONS (PAST AND PRESENT)** |
| **Most recent occurrence:** Click or tap here to enter text. |
| [ ]  Acne[ ]  Chronic urinary/bowel problems[ ]  Hepatitis[ ]  Seizures/epilepsy[ ]  Thyroid disease | [ ]  Anemia[ ]  Diabetes[ ]  HIV/AIDS[ ]  Sexually transmitted infection | [ ]  Asthma[ ]  Eczema/rash[ ]  Migraine/headaches[ ]  Sickle cell anemia |
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| [ ]  Other: | Click or tap here to enter text. | [ ]  Other: | Click or tap here to enter text. |

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| [ ]  Other: | Click or tap here to enter text. | [ ]  Other: | Click or tap here to enter text. |

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| **Are there any additional medical concerns or needs?**Click or tap here to enter text. |
| **12. EDUCATIONAL/SCHOOL INFORMATION** |
| **Last school enrolled:** | Click or tap here to enter text. | **Highest grade level completed:** | Grade |
| **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:** | Date | **Grade(s) repeated:** | Grade |
| **Special classes:** | [ ]  EC | [ ]  LD | [ ]  Resource | [ ]  BED | [ ]  Homebound | [ ]  Day Treatment |
|  | [ ]  Other: Click or tap here to enter text. |
| **History of suspensions or expulsions?** | [ ]  Yes | [ ]  No |
| **If yes, please explain**: Click or tap here to enter text. |
| **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:** Click or tap here to enter text.  |
| **Briefly describe prior offenses and conviction dates (if known)**: Click or tap here to enter text.  |
| **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** |
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| **Does the member eat solid foods?** | [ ]  Yes | [ ]  No | *If no, explain:* | Click or tap here to enter text. |
| **Does the member eat independently?** | [ ]  Yes | [ ]  No | *If no, explain:* | Click or tap here to enter text. |
| **Does the member require special accommodations?** | [ ]  Yes | [ ]  No | *If yes, explain:* | Click or tap here to enter text. |
| **Is there a history of choking/overfilling mouth?**  | [ ]  Yes | [ ]  No |  |  |

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| **TOILETING** |
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| **Is the member continent?** | [ ]  Yes | [ ]  No |
| *If no, indicate brand/size of supplies:* | Click or tap here to enter text. |
| **Can the member use the bathroom alone?** | [ ]  Yes | [ ]  No |
| *If no, explain assistance:* | Click or tap here to enter text. |
| **Does the member wear pull-ups/diapers at night?** | [ ]  Yes | [ ]  No |
| *If yes, indicate brand/size of supplies:* | Click or tap here to enter text. |
| **Will the member tell someone if bathroom is needed?** | [ ]  Yes | [ ]  No |
| **Is the member on a toileting schedule?** | [ ]  Yes | [ ]  No |

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| **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:** | Click or tap here to enter text. |  |
| **List any issues related to sleeping, special equipment needed, etc.:**Click or tap here to enter text. |
| **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:* |
| Click or tap here to enter text. |
| **LANGUAGE** |
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| **Is the member verbal?** | [ ]  Yes | [ ]  No | *If no, complete the questions below:* |
| **How does the member make their needs known?** | Click or tap here to enter text. |
| **Does the member understand one- or two-word commands?** | [ ]  Yes | [ ]  No |
| **Does the member follow one/two-step commands?** | [ ]  Yes | [ ]  No |

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| **Explain any communication needs (devices, etc.):** Click or tap here to enter text.  |
| **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?** Click or tap here to enter text.  |
| **If known, what are triggers for the behavior(s)?** Click or tap here to enter text.  |
| **Does the member usually hurt themselves or others?** | [ ]  Yes | [ ]  No |
| **Describe any other inappropriate behaviors the member may have:** Click or tap here to enter text.  |
| **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.**Click or tap here to enter text. |
| **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** |
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| Click or tap here to enter text. |  | Click or tap here to enter text. |
| **Legally responsible person printed name** |  | **Date** |
| Click or tap here to enter text. |  | Click or tap here to enter text. |
| **Legally responsible person signature** |  | **Date** |
| Click or tap here to enter text. |  | Click or tap here to enter text. |
| **Member signature** |  | **Date** |

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