Trillium HEALTH RESOURCES

Transforming Lives. Building Community Well-Being.

UNIVERSAL CHILD AND ADOLESCENT RESIDENTIAL PLACEMENT APPLICATION

Instructions for completion:

Consistent with System of Care principles, the Universal Child and Adolescent Residential Treatment Application offers a comprehensive clinical review of a member's needs for purposes of admission to a residential provider contracted with Trillium. Instructions for completing the Universal Application are listed below.

1. This application must be completed in its entirety. Please answer each question, indicating "N/A" if not applicable.
2. Do not leave questions or sections blank. Applications may be returned to referring party if deemed incomplete.
3. Do not write "see attached" in sections requiring specific detail. If you have a document that provides greater detail than can be written, reference the document name, date and page number at the end of your explanation. (Ex. Physical Assessment, 7/1/15, Page 3)
4. The person completing this application is responsible for obtaining necessary releases/authorizations to disclose health information.
5. 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/individuals in order to streamline discharge planning and eliminate the time and redundancy associated with multiple agency-specific applications. Use of this form does not, and should not be construed to, guaranteed authorization of residential or other treatment by Trillium.

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:

- ☐ Residential Level I – Family type
- ☐ Residential Level II – Family type
- ☐ Residential Level II – Program type
- ☐ Residential Level III – Group Home
- ☐ Residential Level IV – Secure
- ☐ Psychiatric Residential Treatment Facility (PRTF)

Member Name: _____

Medicaid ID# _____

UNIVERSAL CHILD AND ADOLESCENT RESIDENTIAL PLACEMENT APPLICATION

1. MEMBER DEMOGRAPHIC INFORMATION

Member name:_____ Nickname: _____

Date of birth:_____ Age:_____ Sex: ☐ Male ☐ Female Race:_____

Place of birth:_____ Primary language: _____

SSN:_____ Medicaid #:_____ County of residence: _____

Member's current address: _____

Member's phone number: _____

Current living arrangement: _____

2. LEGALLY RESPONSIBLE PERSON INFORMATION

Is the minor under the care and custody of his or her parent? ☐ Yes ☐ No (If yes, skip to next section.)

Is there a legal guardian/legal custodian appointed by a court of competent jurisdiction? ☐ Yes ☐ No

(If yes, attach copy of court order.)

Name of guardian/custodian: _____

Relationship to member:_____ County of legal custody: _____

Mailing address: _____

Contact information:

Home phone:_____ Work phone:_____ Cell phone: _____

Is there an individual acting *in loco parentis* (such as another relative)? ☐ Yes ☐ No (If yes, explain circumstances under which individual is acting *in loco parentis*.)

Name of individual:_____ Relationship to member: _____

Mailing address: _____

Contact information:

Home phone:_____ Work phone:_____ Cell phone: _____

3. FAMILY INFORMATION

Biological parents are: ☐ Married ☐ Separated ☐ Divorced ☐ Never married ☐ Deceased mother ☐ Deceased father

Have parental rights been terminated? ☐ Yes ☐ No

If so, by whom and when? _____

Member is adopted: ☐ Yes ☐ No ☐ Check here if information pertaining to biological parents is unknown.

Biological mother's name: _____

Address: _____

Telephone numbers: Home: _____ Work: _____ Cell: _____

Date of birth: _____ **Race:** _____

Biological father's Name: _____

Address: _____

Telephone numbers: Home: _____ Work: _____ Cell: _____

Date of birth: _____ **Race:** _____

Siblings or other significant relationship(s):

Name: _____

Telephone numbers: Home: _____ Work: _____ Cell: _____

Address: _____

Additional siblings or other significant relationship(s):

Name: _____

Telephone numbers: Home: _____ Work: _____ Cell: _____

Address: _____

Are there any "no contact" orders currently in place? ☐ Yes ☐ No

Describe: _____

Are there any special conditions/restrictions for home visits? ☐ Yes ☐ No

Describe: _____

4. FAMILY DYNAMICS / FAMILY SOCIAL HISTORY

Include description of family dynamics, family history and significant family events leading up to referral, living arrangement prior to referral and, if removed from family of origin, the circumstances that led to that event.

If other pertinent family history, please document separately and attach.

5. 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: _____

6. PRESENTING PROBLEM / REASON FOR REFERRAL

7. CLINICAL / DIAGNOSTIC INFORMATION

DSM 5 – DIAGNOSTIC INFORMATION

CODE	DIAGNOSIS

CALOCUS score:_____Has member received a psychological evaluation? ☐ Yes ☐ No If yes, when? _____

Examiner:_____Exam date: _____

Is the member diagnosed with an intellectual or developmental disability? ☐ Yes ☐ No

If yes, list the Full Scale Intellectual Quotient (FSIQ):_____ Examiner:_____Date: _____

If yes, list the adaptive scores:_____ Examiner:_____Date: _____

8. MEDICATION INFORMATION

MEDICATION	DOSE / ROUTE	FREQUENCY	INDICATION

9. TREATMENT AND PLACEMENT HISTORY

TREATMENT / PLACEMENT HISTORY (Begin with most current intervention)	DATES (FROM – TO)	REASON FOR DISCHARGE

10. CURRENT SYMPTOMS / OBSERVATIONS

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

☐ Abandonment issues	☐ Anxiety	☐ Arson/fire-setting
☐ Stool/feces smearing	☐ Physical aggression	☐ Verbal aggression
☐ Bedwetting	☐ Eating disorder behaviors	☐ Depression
☐ Property destruction	☐ Homelessness	☐ Hyperactivity
☐ Impulsivity	☐ Lying	☐ Low self-esteem
☐ Loss/grief	☐ Phobias	☐ Sibling-related difficulty
☐ Oppositional	☐ Social immaturity	☐ Stealing
☐ Truancy	☐ Cruelty to animals	☐ Hygiene/cleanliness issues
☐ Problems with sleep	☐ Gang-related activity	☐ History with weapons

Abuse/trauma history:

☐ None ☐ Victim of neglect ☐ Victim of physical abuse ☐ Victim of sexual abuse ☐ Trauma

If checked, provide a brief description:

11. RISK ASSESSMENT

☐ **Self-injurious behavior**	**Check all that apply:** ☐ Cuts on body ☐ Conceals cutting (indicate area _____) ☐ Other forms of self-injury (describe _____) Has self-injury ever required medical attention? ☐ Yes ☐ No Explain: _____
☐ **Suicidal characteristics**	**Check all that apply:** ☐ Suicidal thoughts ☐ Past suicidal attempts ☐ Suicidal plans Describe: _____ Describe methods used in previous attempts: _____ 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: _____ Describe methods used in previous attempts: _____ Were attempts planned? ☐ Yes ☐ No ☐ Sometimes ☐ Don't know Does the member have access to weapons? ☐ Yes ☐ No Explain: _____
☐ **History of elopement**	**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? _____ Where does he/she go? _____ How long is he/she typically away from home/placement? _____
☐ **Sexualized behaviors**	**Check all that apply:** ☐ Sexual acting-out ☐ Deviant sexual behavior ☐ Sexual exploitation ☐ Other (describe):
☐ **Psychotic symptoms**	**Check all that apply:** ☐ Auditory hallucinations ☐ Visual hallucinations ☐ Delusions ☐ Other (describe):

12. SUBSTANCE USE INFORMATION

☐ N/A - Proceed to next section

Type of Substance	Route	Frequency	Last Use
☐ Alcohol			
☐ Amphetamines			
☐ Cocaine			
☐ Hallucinogens			
☐ Heroin / Opiates			
☐ Inhalants			
☐ Marijuana			
☐ Other: _____			

13. MEDICAL INFORMATION

Weight:_____ Height: _____ Date of last physical exam:_____

Allergies: _____ Drug allergies: _____

Special dietary needs: _____

Medical conditions (past and present); note most recent occurrence:

☐ Acne ☐ Chronic urinary/bowel problems ☐ Hepatitis ☐ Seizures

☐ Anemia ☐ Diabetes ☐ HIV/AIDS ☐ Sexually transmitted disease

☐ Asthma ☐ Eczema ☐ Migraine headaches ☐ Sickle cell anemia

☐ Other:_____ ☐ Other: _____

☐ Other: _____ ☐ Other: _____

Name/address of pediatrician: _____

Date of last dental exam: _____ Dental appliances: ☐ Yes ☐ No

Name / address of dentist: _____

Date of last eye exam: _____ Corrective lenses: ☐ Yes ☐ No

Name / address of eye doctor: _____

14. INSURANCE COVERAGE

Health Insurance coverage: ☐ Medicaid ☐ N.C. Health Choice ☐ Medicare ☐ TriCare ☐ N.C. State Health Plan ☐ Private health insurance ☐ Other: _____

Insurance policy number: _____ Group number: _____

Name of policy holder: _____

Any other third party insurance: _____

15. AGENCY INVOLVEMENT

Indicate agencies currently involved. Check all that apply:

☐ Trillium care coordinator	Name: _____	Phone: _____
☐ DSS County: _____	Social Worker: _____	Phone: _____
☐ Clinical home provider	Name: _____	Phone: _____
☐ Guardian ad Litem (GAL)	Name: _____	Phone: _____
☐ DJJ court counselor	Name: _____	Phone: _____
☐ Other: _____	Name: _____	Phone: _____
☐ Other: _____	Name: _____	Phone: _____

16. EDUCATIONAL / SCHOOL INFORMATION

Last school enrolled: _____

District: _____ Highest grade level completed: _____

Current IEP? ☐ Yes ☐ No Date _____ Grade(s) repeated: _____

Special Classes: ☐ EC ☐ LD ☐ Resource ☐ Homebound ☐ Other: _____

Suspensions or expulsions: _____

17. LEGAL HISTORY

☐ N/A - Proceed to next section

Does member have a criminal record? ☐ Yes ☐ No Is member on probation? ☐ Yes ☐ No

Pending charges? ☐ Yes ☐ No Charges: _____

List brief description of prior offenses and conviction dates (if known):

Attach any court orders applicable to this member.

18. STRENGTHS / ABILITIES / PREFERENCES

Personal strengths, assets and capabilities:

Natural supports:

Religious, spiritual and/or cultural considerations:

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

19. TREATMENT GOALS

☐ Please attach a copy of member's Person-Centered Plan/Individual Support Plan (if applicable), including identification of the service(s) being requested.

☐ If the member is currently admitted to an inpatient facility, attach a copy of his or her Inpatient Treatment Plan, including identification of the service(s) being requested.

20. ADDITIONAL INFORMATION

Provide information related to the member's current status, symptoms, notable improvements/changes, etc. Also, include any additional comments that may support this application.

21. REFERRAL CHECKLIST

In the second column, indicate each item that is attached to this application. Please comment on reasons items are missing or items that will be sent at later time.

CCA/psychiatric assessment/evaluations/diagnostic assessment	☐ Attached Comment: _____
Person-Centered Plan/ISP/Inpatient Treatment Plan	☐ Attached Comment: _____
Psychological testing	☐ Attached Comment: _____
Physical assessment/medical information	☐ Attached Comment: _____
Sexually Aggressive Youth Evaluation / Sex Offender-Specific Evaluation	☐ Attached Comment: _____
DSS records (if applicable)	☐ Attached Comment: _____
DJJ records (if applicable)	☐ Attached Comment: _____
Court orders (if applicable)	☐ Attached Comment: _____
Signed Authorization and Consent for Release of Information	☐ Attached Comment: _____
Other:	☐ Attached Comment: _____

SIGNATURES

_____ Treatment service coordinator printed name	_____ Date
_____ Treatment service coordinator signature	_____ Date
_____ Legally responsible person printed name	_____ Date
_____ Legally responsible person signature	_____ Date
_____ Member's signature	_____ Date