



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.

Date referral form completed:		Date service needed:	
Type of referral/Level of Care sought			
<input type="checkbox"/> Residential Level I – Family type		<input type="checkbox"/> Residential Supports, Group home – NC Innovations Waiver	
<input type="checkbox"/> Residential Level II – Family type		<input type="checkbox"/> Non-Medicaid-Funded Residential Services – Group home or AFL	
<input type="checkbox"/> Residential Level II – Program type		<input type="checkbox"/> Long-Term Community Supports – intellectual/developmental disability (I/DD) residential services (Medicaid)	
<input type="checkbox"/> Residential Level III – Group home		<input type="checkbox"/> Individual Supports – Mental health (Medicaid)	
<input type="checkbox"/> Residential Level IV – Secure		<input type="checkbox"/> Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)	
<input type="checkbox"/> Psychiatric Residential Treatment Facility (PRTF)			
<input type="checkbox"/> Emergent Need Respite – internal referrals only			
<input type="checkbox"/> Residential Supports, Alternative Family Living (AFL) – NC Innovations Waiver			
Member name:			
Is the member a Medicaid beneficiary? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, Medicaid ID#:	
LME/MCO or PHP benefit plan:			
Does the member have a CCA? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, date of most recent CCA:	
<i>Note: A CCA is required to approve the placement of a child/youth in a leveled Medicaid-supported plan.</i>			



1. 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: _____

Reason for referral:

2. MEMBER DEMOGRAPHIC INFORMATION

Member name: _____ Preferred name: _____

Date of birth: _____ Age: _____ Gender assigned at birth: Male Female

Gender identity: _____ Pronouns: _____ Sexual orientation: _____

Race: _____ Place of birth: _____

Primary language: _____ Does the member speak English? Yes No

County from which Medicaid originates:

What counties are you open to placement in? Any Specific counties (please list below)

Current living arrangement:

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.)*

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):

3. LEGALLY RESPONSIBLE PERSON INFORMATION

Who is legally responsible for the child? Parent Guardian County DSS Other

Name of guardian/custodian: _____ Relationship to member: _____

If in DSS custody, county of legal custody: _____ Permanency plan: _____

Has there been a termination of parental rights? Yes No

If yes, date and by whom:

Home phone: _____ Work phone: _____ Mobile phone: _____

Mailing address: _____ Email: _____

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?

Are there religious, spiritual, or cultural considerations?

Are there existing visitations? Yes No

Are the visits supervised? Yes No

If yes, by who?

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.)*

Does the member have siblings? Yes No

If yes, list their first names:

Are you seeking placement of the siblings together? Yes No

If yes, which siblings?

5. CLINICAL/DIAGNOSTIC INFORMATION

DSM-5 – DIAGNOSTIC INFORMATION

CODE	DIAGNOSIS

Primary diagnosis:

Secondary diagnosis:

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

7. TREATMENT AND PLACEMENT HISTORY

Number of out-of-home placements:

Has the member been hospitalized? Yes No **If yes, how many times in the past year?**

Has the member been in residential placement in the past year? Yes No

If yes, where?

Has the member had a psychosexual evaluation? Yes No

If yes, date of most recent:

Has the member had a trauma evaluation? Yes No

If yes, date of most recent:

Has the member received trauma treatment? Yes No

Describe:

8. CURRENT SYMPTOMS/OBSERVATIONS

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

<input type="checkbox"/> Abandonment issues	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Difficulties at school
<input type="checkbox"/> Stool/feces smearing	<input type="checkbox"/> Sexually inappropriate behavior	<input type="checkbox"/> Fire-starting/arson
<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Eating disorder behaviors	<input type="checkbox"/> Problems with sleep
<input type="checkbox"/> Property destruction	<input type="checkbox"/> Homelessness	<input type="checkbox"/> Hyperactivity
<input type="checkbox"/> Impulsivity	<input type="checkbox"/> Lying	<input type="checkbox"/> Low self-esteem
<input type="checkbox"/> Loss/grief	<input type="checkbox"/> Phobias	<input type="checkbox"/> Sibling-related difficulty
<input type="checkbox"/> Oppositional	<input type="checkbox"/> Social immaturity	<input type="checkbox"/> Stealing
<input type="checkbox"/> Truancy	<input type="checkbox"/> Cruelty to animals	<input type="checkbox"/> Hygiene/cleanliness issues
<input type="checkbox"/> Hygiene/cleanliness issues	<input type="checkbox"/> Gang-related activity	<input type="checkbox"/> History with weapons

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:

9. RISK ASSESSMENT

<input type="checkbox"/> Self-injurious behavior	<p>Check all that apply: <input type="checkbox"/> Cuts on body <input type="checkbox"/> Conceals cutting, <i>indicate area:</i> _____</p> <p><input type="checkbox"/> Other forms of self-injury, <i>Describe:</i> _____</p> <p>Has self-injury ever required medical attention? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Explain:</p>
<input type="checkbox"/> Suicidal characteristics	<p>Check all that apply: <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Past suicide attempts <input type="checkbox"/> Suicidal plans</p> <p>If checked above, describe:</p> <p>_____</p> <p>Describe methods used in previous attempts:</p> <p>_____</p> <p>Were attempts planned? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Unknown</p>
<input type="checkbox"/> Homicidal characteristics	<p>Check all that apply: <input type="checkbox"/> Homicidal thoughts <input type="checkbox"/> Past attempts to harm others <input type="checkbox"/> Homicidal plans</p> <p>If checked above, describe:</p> <p>_____</p> <p>Describe methods used in previous attempts:</p> <p>_____</p> <p>Were attempts planned? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Unknown</p> <p>Does the member have access to weapons? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Explain:</p>
<input type="checkbox"/> History of elopement	<p>Check all that apply: <input type="checkbox"/> Runs away from home <input type="checkbox"/> Has run from previous placements</p> <p>In the past year, how many times has the member run away? _____</p> <p>Where does the member go? _____</p> <p>How long are they typically away from home/placement? _____</p>

<input type="checkbox"/> Sexualized behaviors	Check all that apply: <input type="checkbox"/> Sexual acting-out <input type="checkbox"/> Deviant sexual behavior <input type="checkbox"/> Sexual exploitation <input type="checkbox"/> Other (describe) _____
<input type="checkbox"/> Psychotic symptoms	Check all that apply: <input type="checkbox"/> Auditory hallucinations <input type="checkbox"/> Visual hallucinations <input type="checkbox"/> Delusions <input type="checkbox"/> Other (describe) _____

10. SUBSTANCE USE INFORMATION N/A – PROCEED TO NEXT SECTION

TYPE OF SUBSTANCE	ROUTE	FREQUENCY	LAST USE
<input type="checkbox"/> Alcohol			
<input type="checkbox"/> Amphetamines			
<input type="checkbox"/> Cocaine			
<input type="checkbox"/> Hallucinogens			
<input type="checkbox"/> Heroin/opiates			
<input type="checkbox"/> Inhalants			
<input type="checkbox"/> Marijuana			
<input type="checkbox"/> Nicotine/e-cigs/JUULs			
<input type="checkbox"/> Benzodiazepines/hypnotics			
<input type="checkbox"/> Other (specify): _____			

11. MEDICAL INFORMATION

Allergies:	Drug allergies:
Special dietary needs:	
Is the youth up-to-date on CDC-recommended vaccines for their age group? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the youth ever declined or delayed a a CDC-recommended vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the youth received vaccination(s) for COVID-19? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, include the total number of doses received and the dates for the vaccination dose(s), if known:	
Height of child:	Weight of child:

MEDICAL CONDITIONS (PAST AND PRESENT)

Most recent occurrence:

<input type="checkbox"/> Acne	<input type="checkbox"/> Anemia	<input type="checkbox"/> Asthma
<input type="checkbox"/> Chronic urinary/bowel problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Eczema/rash
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Migraine/headaches
<input type="checkbox"/> Seizures/epilepsy	<input type="checkbox"/> Sexually transmitted infection	<input type="checkbox"/> Sickle cell anemia
<input type="checkbox"/> Thyroid disease		
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Other: _____	

Are there any additional medical concerns or needs?

12. EDUCATIONAL/SCHOOL INFORMATION

Last school enrolled:	Highest grade level completed:
Is it important the member remain in their current school? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Can the member attend a full day of school? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the member have a current IEP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date:
Grade(s) repeated:	
Special classes: <input type="checkbox"/> EC <input type="checkbox"/> LD <input type="checkbox"/> Resource <input type="checkbox"/> BED <input type="checkbox"/> Homebound <input type="checkbox"/> Day Treatment <input type="checkbox"/> Other:	
History of suspensions or expulsions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:	

13. LEGAL HISTORY N/A – PROCEED TO NEXT SECTION

Does the member have a criminal record? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is the member on probation? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are there pending charges? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Charge(s) and counties where charge occurred:	
Briefly describe prior offenses and conviction dates (if known):	

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

Does the member eat solid foods?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If no, explain:</i> _____
Does the member eat independently?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If no, explain:</i> _____
Does the member require special accommodations?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If yes, explain:</i> _____
Is there a history of choking/overfilling mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

TOILETING

Is the member continent?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If no, indicate brand/size of supplies:</i> _____
Can the member use the bathroom alone?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If no, explain assistance:</i> _____
Does the member wear pull-ups/diapers at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If yes, indicate brand/size of supplies:</i> _____
Will the member tell someone if bathroom is needed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the member on a toileting schedule?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

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: _____

List any issues related to sleeping, special equipment needed, etc.:

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:*

LANGUAGE

Is the member verbal? Yes No *If no, complete the questions below:*

How does the member make their needs known?

Does the member understand one- or two-word commands? Yes No

Does the member follow one/two-step commands? Yes No

Explain any communication needs (devices, etc.):

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?

If known, what are triggers for the behavior(s)?

Does the member usually hurt themselves or others? Yes No

Describe any other inappropriate behaviors the member may have:



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.

16. REFERRAL CHECKLIST

Please attach any of the following that are available:

- | | |
|---|--|
| <input type="checkbox"/> Up-to-date person-centered plan and/or Individual Support Plan | <input type="checkbox"/> DSS records |
| <input type="checkbox"/> Inpatient treatment plan | <input type="checkbox"/> DJJ records |
| <input type="checkbox"/> Up-to-date CCA/psychiatric assessment/evaluations/diagnostic assessments | <input type="checkbox"/> Court orders |
| <input type="checkbox"/> Psychological testing | <input type="checkbox"/> Signed Authorization and Consent for Release of Information |
| <input type="checkbox"/> Physical assessments/medical information | <input type="checkbox"/> Other |
| <input type="checkbox"/> Sexually Aggressive Youth Evaluation/ Sex Offender-Specific Evaluation | |

17. SIGNATURES

_____ **Legally responsible person printed name**

_____ **Date**

_____ **Legally responsible person signature**

_____ **Date**

_____ **Member signature**

_____ **Date**