

Consumer Name:

Medicaid Number:

Record Number:



Universal Residential Application

Date of Application: _____

Date of Service Needed: _____

Type of referral Needed/CFT Recommendation:

- Residential Treatment Level 2
 Residential Treatment Level 3
 Psychiatric Residential Treatment Facility

Section I: Consumer Information

Consumer's Name: _____ Nickname: _____
 Social Security Number: _____ Date of Birth: _____ Age: _____ Sex: _____
 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.): _____

Section II: Guardian Information

Legal Guardian: _____
 Relationship: _____ County of Legal Custody: _____
 Guardian's Address: _____
 Guardian's Phone Number: _____ Cell: _____
 If a Guardian ad Litem has Been Appointed Please List Name and Contact Number:

Section III: Consumer Primary Referral Source Information:

Referring Agency: Support DJJ DSS County: _____
 Other: _____
 Provider Agency: _____ Phone #: _____
 Agency Contact Person: _____ Phone #: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Emergency Contact: _____ Relationship to Consumer: _____
 Contact #: _____ Fax#: _____ Pager/Cell#: _____
 Address: _____

Section V: Medical Information

Allergies: _____

Special Dietary Needs: _____

Medical Conditions (past and present): Please note most recent occurrence

- | | | |
|---|---|---|
| <input type="checkbox"/> Lice | <input type="checkbox"/> Bulimia | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Anorexia | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Measles | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Mumps | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Ringworm | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Chronic Urinary/Bowel Problems | <input type="checkbox"/> Rubella | <input type="checkbox"/> TBI |

Other: _____ Other: _____ Other: _____

Name and Address of Pediatrician: _____

Name and Address of Dentist: _____

Date of Last Phys. Exam: _____ Last Dental Exam: _____ Last Eye Exam: _____

Dental Appliances: Yes No Contacts/Glasses: Yes No

Medical Insurance Company: Medicaid _____ NC Health Choice _____

Private Ins.(Agency): _____

Insurance Policy Number: _____

Insurance is in Whose Name? _____

Any Other Third Party Insurance? _____

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Section IX: Placement History		
Placement (Begin w/Current Placement)	Dates (From – To)	Reason for Discharge

Section X: Current Emotional/Behavioral Problems		
Please describe behavior and date of the last incident.		
<input type="checkbox"/> Abandonment Issues	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Arson
<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> Antisocial Behavior	<input type="checkbox"/> Stool/Feces smearing
<input type="checkbox"/> Assaultive (Physical)	<input type="checkbox"/> Assaultive (Sexual)	<input type="checkbox"/> Assaultive (Verbal)
<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Depression
<input type="checkbox"/> Property Destroying	<input type="checkbox"/> Fire Setter	<input type="checkbox"/> Developmental Disability
<input type="checkbox"/> Homeless	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Impulsive
<input type="checkbox"/> Lying	<input type="checkbox"/> Low Self-Esteem	<input type="checkbox"/> Loss/Grief Difficulties
<input type="checkbox"/> Physical Impairment	<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Parent Neglect Issues
<input type="checkbox"/> Perception of Reality	<input type="checkbox"/> Phobic Behavior	<input type="checkbox"/> Physical Disability
<input type="checkbox"/> Self-Destructive Behavior	<input type="checkbox"/> Sibling Related Difficulty	<input type="checkbox"/> Oppositional
<input type="checkbox"/> Social Immaturity	<input type="checkbox"/> Sexually Inappropriate Behavior	<input type="checkbox"/> Stealing
<input type="checkbox"/> Suicidal	<input type="checkbox"/> Running Away	<input type="checkbox"/> Truancy
<input type="checkbox"/> Unruly/Ungovernable	<input type="checkbox"/> Cruelty to Animals	<input type="checkbox"/> Hygiene/Cleanliness Issues
<input type="checkbox"/> Problems with Sleep	<input type="checkbox"/> Gang Related Activity	<input type="checkbox"/> History w/ Weapons
Other: _____		

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Aggressive or Violent Behavior Alert

Please describe the nature of the acting out behaviors:

Verbally Aggressive, Frequency: _____

Description: _____

Physically Aggressive, Frequency: _____

Description: _____

Property Destruction, Frequency: _____

Description: _____

Has the Behavior Resulted in Injury to Others? Criminal Charges? Please describe:

Aggression is: Impulsive Planned Instrumental Triggered by Fearfulness

Where is the Client Aggressive:

Known Triggers, Please Describe:

Main Targets of Aggression: Peers Authority Figures Family Members (Please be specific)

Please Describe the Most Recent Episode of Aggression

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History of Self-Injurious/ Risky Behaviors	
Self-Injury	<p>Check all that apply:</p> <input type="checkbox"/> Cuts on Body <input type="checkbox"/> Conceals Cutting- Indicated Area <input type="checkbox"/> Other Forms of Self-Injury (please describe): _____ Has Self-Injury ever Required Medical Attention? <input type="checkbox"/> Yes <input type="checkbox"/> No (Please explain): _____ _____
Suicidal Characteristics	<p>Check all that apply:</p> <input type="checkbox"/> Suicidal Thoughts <input type="checkbox"/> Past Suicide Attempts <input type="checkbox"/> Suicidal Plans (describe): _____ Methods Used in Previous Attempts (describe): _____ Were Attempts Planned: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Don't know
Homicidal Characteristics	<p>Check all that apply:</p> <input type="checkbox"/> Homicidal Thoughts <input type="checkbox"/> Past Attempts to Harm Others <input type="checkbox"/> Homicidal Plans (describe): _____ Methods Used in Previous Attempts (please describe): _____ Were Attempts Planned: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/> Don't know Does Consumer have Access to Weapons? <input type="checkbox"/> Yes <input type="checkbox"/> No Please Explain: _____
History of AWOL	Runs Away from Home: <input type="checkbox"/> Yes <input type="checkbox"/> No Has Run from Previous Placements: <input type="checkbox"/> Yes <input type="checkbox"/> No In the Past Year how Many Times has Consumer Run? _____ Where Does He/She Go? _____ How Long is Consumer Typically AWOL? _____
Substance Abuse History	<p>Check all that apply:</p> <input type="checkbox"/> Marijuana Frequency: _____ - Last Used: _____ <input type="checkbox"/> Cocaine Frequency: _____ - Last Used: _____ <input type="checkbox"/> Heroin/Opiates Frequency: _____ - Last Used: _____ <input type="checkbox"/> Amphetamines Frequency: _____ - Last Used: _____ <input type="checkbox"/> Inhalants Frequency: _____ - Last Used: _____ <input type="checkbox"/> Hallucinogens Frequency: _____ - Last Used: _____ <input type="checkbox"/> Alcohol Frequency: _____ - Last Used: _____ <input type="checkbox"/> Other: Frequency: _____ - Last Used: _____ Explain: _____
Sexual Behaviors	Describe any Sexualized Behaviors Exhibited by Consumer (i.e. peeping, sexual acting out, predatory behaviors, prostitution): _____ _____ _____ _____
Psychotic Behaviors	Please Describe any Past/Present History of Psychosis: _____ _____ _____ _____

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Section XI: Family Information

Biological Mother's Name: _____

Address: _____

Telephone Number: Home: _____ Work: _____ Cell: _____

Ethnicity: _____ Education Level: _____ (Unknown)

Criminal Record: Yes No Unknown

Biological Father's Name: _____

Address: _____

Telephone Number: Home: _____ Work: _____ Cell: _____

Ethnicity: _____ Education Level: _____ (Unknown)

Criminal Record: Yes No Unknown

Check all that apply:

Are Parents: Married Separated Divorced Never Married Deceased Mother Deceased Father

Have Parental Rights Been Terminated: Yes No

If so, Who and When?

Siblings:

Name	Age	Gender

Are Siblings in Out-of-Home Placements? Yes No

If yes, please specify: DSS Foster Care Relatives Incarcerated Group Home Other:

Explain: _____

Section XII: 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.

