UNIVERSAL APPLICATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
CHILDREN AND FAMILY SERVICES
SFN 824 (5-2010)

Clear Fields

APPLICATION FOR RESIDENTIAL, INTENSIVE IN-HOME, FAMILY GROUP DECISION-MAKING AND PARTNERSHIPS SERVICES

This application must be filled out as completely as possible.

If this application has been completed within the last year and requires only an update please attach a brief narrative to this application.

By completing this application I understand that its contents may be shared with agencies involved in services. I have completed & attached the multi-agency release of information for this purpose (SFN 970).

Parent/Guardian Signature
Custodian Signature

SERVICE(S) APPLYING FOR (mark all that apply):

☐ Partnerships (multi-agency needs) ☐ Family Group Decision-Making ☐ Intensive In-home Services

Residential:

☐ PATH ☐ North Homes

☐ Group Home _____

☐ Residential Child Care Facility (RCCF) _____

☐ Psychiatric Residential Treatment Facility (PRTF) _____

REFERRAL REASONS (check up to TWO Primary reasons per family unit):

☐ Referred by Child & Family Team
☐ Early Intervention
☐ Services Required
☐ Services Recommended
☐ Reunification
☐ Juvenile Court/DJS
☐ Prevent Adoption Disruption
☐ Social Service Case Management
☐ Other: _____

Referral Reason Narrative (optional)

REFERRAL CONCERNS/RISK FACTORS (check up to TWO primary risks per family):

☐ Child Abuse/Neglect
☐ Substance Abuse
☐ Serious Mental Health Issues
☐ Law Violations/Domestic Violence/Incarcerations (Adults)
☐ Rule Violations/Status Offense/Delinquency (Youth)
☐ Prior Placement History of Child/ren
☐ Physical/Developmental Disability (Child or Adult)
☐ Parent/Child Conflict/Family Discord
☐ Joblessness/Financial/Housing
☐ Educational
☐ Other: _____

Explanation of Referral Concerns/Risk Factors
Risk of Placement without Services ☐ Imminent ☐ High ☐ Moderate ☐ Low
Immediate Safety Concerns

REFERRAL INFORMATION

Date of Referral	Completed By (Signature)		
Legal Custodian			
Agency Name	Telephone Number	Fax Number	
Address	City	State	ZIP Code
Court Order Date	County of Financial Responsibility	Tribal Affiliation	
Tribal Enrollment Number	If not enrolled, is child enrollable ☐ Yes ☐ No		
Name of Desired Facility for Placement			

Client's Name				Gender ☐ Male ☐ Female
Date of Birth	Age	Place of Birth		Social Security Number
Height	Weight	Race	Religion	Is child adopted ☐ Yes ☐ No
Culture (customs, traditions, heritage, ancestry, etc.)				

CURRENT RESIDENCE OR PLACEMENT OF YOUTH (i.e. foster home, parental home)

Name of Foster Parent(s)/Facility			Telephone Number
Address	City	State	ZIP Code
Medicaid Eligible ☐ Yes ☐ No ☐ Unknown	Medicaid (MA) Number	County Issuing MA Number	Recipient Liability ☐ Yes ☐ No ☐ Unknown
Estimated Recipient Liability (average per month)	Who will secure the letter from the physician recommending services for intensive in-home ☐ Therapist ☐ County Worker		

Title IV-E Eligible	Emergency Assistance (EA) Eligible	SSI Eligible	SSDI Eligible
☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

Third Party Insurance Company Name	Telephone Number	Fax Number	
Address	City	State	ZIP Code
Name of Policy Holder	Telephone Number	Fax Number	
Address	City	State	ZIP Code
Policy Number			

Description of Present Treatment Issues (including current symptoms/behaviors, severity and nature of all preceding treatment issues)

Brief Description of Child Abuse/Neglect History
Current contact, if any, with known perpetrator(s) of abuse/neglect ☐ Yes ☐ No ☐ Unknown
Explain

FAMILY ORIGIN

Father's Name			Home Telephone Number	Work Telephone Number	
Address			City	State	ZIP Code
Date of Birth	Age	Race	Religion	Marital Status	
Employed ☐ Yes ☐ No		Occupation			
Level of Education			Level of Contact with Child ☐ Active ☐ Inactive ☐ Unknown		
Explain					

Step Father's Name			Home Telephone Number	Work Telephone Number	
Address			City	State	ZIP Code
Date of Birth	Age	Race	Religion	Marital Status	
Employed ☐ Yes ☐ No		Occupation			
Level of Education			Level of Contact with Child ☐ Active ☐ Inactive ☐ Unknown		
Explain					

Mother's Name			Home Telephone Number	Work Telephone Number	
Address			City	State	ZIP Code
Date of Birth	Age	Race	Religion	Marital Status	
Employed ☐ Yes ☐ No		Occupation			
Level of Education			Level of Contact with Child ☐ Active ☐ Inactive ☐ Unknown		
Explain					

Step Mother's Name			Home Telephone Number	Work Telephone Number	
Address			City	State	ZIP Code
Date of Birth	Age	Race	Religion	Marital Status	
Employed ☐ Yes ☐ No		Occupation			
Level of Education			Level of Contact with Child ☐ Active ☐ Inactive ☐ Unknown		
Explain					

Does either parent/step parent currently have a significant other living with him/her ☐ Yes ☐ No	If yes, which parent
Does the significant other have youth living with him/her in the home ☐ Yes ☐ No	

SIBLINGS

NAME	AGE	SEX	ADDRESS	RELATIONSHIP

Other Significant People in Youth's Life (peers, church, extended family, neighbors, etc.)

Description of Family Strengths (accomplishments, coping skills, etc.)
Description of Youth Strengths (spiritual, special interests, hobbies, talents, work, recreation, leisure, vocation etc.)
Family History (divorce, domestic violence, family dynamics, etc.)

Child's Probation Officer	Telephone Number	Fax Number	
Address	City	State	ZIP Code
Reason for Probation			
Date Probation Expires			

Guardian Ad Litem	Telephone Number	Fax Number	
Address	City	State	ZIP Code

SERVICES
Provide a brief description of current and/or past services

	START/END DATES	FREQUENCY	FACILITY	OUTCOME
Individual Therapy				
Family Therapy				
Group Therapy				
Intensive In-Home				
Parent Aide				
Case Aide				
Respite				
Prior Inpatient Treatment				
Prior Outpatient Treatment				
Chemical Dependency				
Other				

DIAGNOSIS

Source	Date
Axis I	
Axis II	
Axis III	

AXIS IV	Specify Problem
☐ Problems with Primary Support Group	
☐ Problems Related to the Social Environment	
☐ Educational Problems	
☐ Occupational Problems	
☐ Housing Problems	
☐ Economic Problems	
☐ Problems with Access to Health Care Services	
☐ Problems Related to Interaction with the Legal System	
☐ Other Psychosocial and Environmental Problems	

AXIS V

Global Assessment of Functioning (GAF) Scale	GAF Scale with Supports	GAF Scale without Supports
Key Findings		

Symptoms Requiring Inpatient Care	
Month/Year Symptoms Started	Most Recent Date

INTERVENTIONS	EFFECTIVENESS/OUTCOMES

Chronic Behaviors	
Month/Year Symptoms Started	Most Recent Date

INTERVENTIONS	EFFECTIVENESS/OUTCOMES

DRUG/ALCOHOL USE

TYPE OF SUBSTANCE	AGE FIRST USED	AGE REGULAR USE	DATE LAST USED	AMOUNT	RATE OF USE IN THE PAST 6 MONTHS

Laboratory Tests	
Lab Type	Date Completed
Findings	

FAMILY SUPPORT SYSTEM

NAME	RELATIONSHIP	DESCRIPTION OF SUPPORT	INVOLVED IN TREATMENT	LEVEL OF SUPPORT PROVIDED
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

For Partnerships/Intensive In-Home/Residential services- please attach written documentation of child's diagnosis and GAF score from a qualified mental health professional from within the last year.

PLACEMENT HISTORY (most current first) i.e. family foster care, therapeutic foster care, PRTF, RCCF, inpatient, relative care)

PROVIDER NAME AND ADDRESS	ENTRY DATE	REASON FOR PLACEMENT	TX PLAN COMPLETED	DISCHARGE DATE	OUTCOME
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		
			☐ Yes ☐ No		

HISTORY OF YOUTH'S BEHAVIOR/TREATMENT (may describe youths behavior/treatment in an attached narrative and/or complete section below)

1. Destructiveness (include fire-setting)
2. Aggressiveness
3. Sexual Offending
4. Relationship with Peers/Classmates
5. Relationship with Adults

6. Relationship with Authority/Teachers/Counselors
7. Harm to Self (cutting, burning, etc)
8. Danger/Violence to Others (include animals)
9. Eating And Sleeping Habits (eating and sleeping disorder)
10. Danger To Self/Suicide Attempts/Ideation (youth)
11. Mental Illness History (family)
12. Piercing/Tattoos (without parental consent)
13. History of Sexuality (sexually active, STD's, pregnancy, etc.)

NOTE: For youth ages 14 and above, a release of information must be signed by the youth only for release of drug and alcohol treatment records. Parents/guardians are not able to access the youth's records without signed permission by the youth. Please attach release of information if applicable.

14. Alcohol/Drug Usage, Including Smoking, Huffing (youth)

HISTORY OF YOUTH'S BEHAVIOR/TREATMENT (continued)

15. Alcohol/Drug Usage, Including Smoking, Huffing (parental/other family members)
Has client been assessed for Fetal Alcohol Syndrome/Fetal Alcohol Effects ☐ Yes ☐ No
If yes, what were the results

16. Legal History		
Runaway Risk/History		
Describe Any Restitution/Community Service		
Hours	Date	Amount

17. Other

EDUCATION

Home School District		Current School Attending		
Superintendent's Name		Telephone Number	Fax Number	
Address		City	State	ZIP Code
School Contact		Telephone Number	Fax Number	
Address		City	State	ZIP Code
Present Grade Level	Last Grade Completed	Received GED ☐ Yes ☐ No	Date GED Received	
Receiving Special Education ☐ Yes ☐ No	Receiving IEP ☐ Yes ☐ No	Category ☐ LD ☐ ED ☐ Speech/Language ☐ 504 ☐ Other		

EDUCATION (continued)

Special Education District		Telephone Number	Fax Number	
Address		City	State	ZIP Code
Verbal IQ Score	Performance IQ	Full Scale IQ	Date	
Date of Cognitive Evaluation	Type of IEP		Current ED IEP Date	

Educational Strengths, Interests, and Achievements

EDUCATIONAL DEVELOPMENT (history of learning/perceptual problems, sensory deficits, dyslexia, etc.)

ATTENDANCE HISTORY (punctuality, approximate number of excused and unexcused absences, etc.)

Past Year Performance (average grades)	Present Year Performance (average grades)	Has school been informed of referral? ☐ Yes ☐ No
Independent Living Coordinator Name		Telephone Number

END OF PARTNERSHIPS APPLICATION
PLEASE RETAIN A COPY OF THIS FORM FOR YOUR RECORDS

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PLEASE CONTINUE APPLICATION PROCESS FOR RESIDENTIAL/ INTENSIVE IN-HOME & FAMILY GROUP DECISION-MAKING

MEDICAL HISTORY

Known Medical Problems/Disabilities/Head Injuries (include allergies: medications, food, insects etc.)

Current Medications

DRUG NAME	DOSAGE	PURPOSE	DATES USED	FREQUENCY OF CHECKS	PRECAUTIONS

Medications Taken Within Last Year

IMMUNIZATION RECORD MUST BE PROVIDED TO THE FACILITY

Family Doctor	Telephone Number	Date	
Address	City	State	ZIP Code

Dentist	Telephone Number	Date	
Address	City	State	ZIP Code

Optometrist	Telephone Number	Date	
Address	City	State	ZIP Code

Psychologist	Telephone Number	Date	
Address	City	State	ZIP Code

Psychiatrist	Telephone Number	Date	
Address	City	State	ZIP Code

LEVEL OF ENGAGEMENT/INVOLVEMENT

Youth's Motivation/Stage of Readiness and Engagement/Involvement in Treatment (referral's perception of youth's cooperation)
Family's Engagement/Involvement in Treatment (referral's perception of family's cooperation)

POST-DISCHARGE PLAN

If this youth is accepted, what is the plan following discharge

END OF RESIDENTIAL SERVICES & INTENSIVE IN-HOME SERVICES APPLICATION

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CONTINUE TO COMPLETE THE FOLLOWING SECTION FOR FAMILY GROUP DECISION-MAKING SERVICES

FAMILY GROUP DECISION-MAKING SERVICES

Has the family agreed to participate in Family Group Decision-Making meeting ☐ Yes ☐ No
What is the GOAL/PURPOSE of Family Group Decision-Making meeting
Has the family agreed to the GOAL/PURPOSE of meeting ☐ Yes ☐ No
Does the family have any cultural or language needs ☐ Yes ☐ No
If yes, explain

Persons to be invited to the conference (family, friends, service providers)

NAME	ADDRESS	TELEPHONE NUMBER	RELATIONSHIP TO CHILD/PARENT

Parent or Guardian Consent for FGDM Services

I consent that the other people invited to participate in the Family Group Decision-Making Conference may hear information about me and my child (ren). I specifically authorize the County Social Services Agency, other service providers, family members and other conference participants to share information about me with the Conference Facilitator, so that the facilitator can be fully informed. I also consent to the Social Services staff and the facilitator sharing and exchanging information with the other conference participants.

Name		Telephone Number	
Address	City	State	ZIP Code

Authorizing Agency Representative Signature	Date
Parent (s)/Guardian Signature	Date
Youth (over 14 years of age) Signature	Date

PLEASE RETAIN A COPY OF THIS APPLICATION FOR YOUR RECORDS