



UNIVERSAL APPLICATION
 DEPARTMENT OF HEALTH AND HUMAN SERVICES
 CHILDREN AND FAMILY SERVICES
 SFN 824 (7-2024)

Directions: This form is completed by the custodian (public agency worker or a parent or guardian if child is not in North Dakota foster care) detailing current and immediate need for out of home treatment. In addition to this form; the custodian, parent, or guardian must attach additional information to support the need for treatment. If referred by a **parent or guardian**, the completed form must first be submitted to the HHS screener.

CHILD DEMOGRAPHICS AND INFORMATION SOURCES

Last Name	Name (First, Middle Initial)	Date of Birth
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Current Residence Address	City	State	ZIP Code
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Child's Current Living Arrangement (or type - e.g., home, foster home, etc.)

<input type="checkbox"/> Family Setting (parents)	<input type="checkbox"/> Qualified Residential Treatment Program (QRTP)
<input type="checkbox"/> Family Setting (relatives) (specify): _____	<input type="checkbox"/> Psychiatric Residential Treatment Facility (PRTF)
<input type="checkbox"/> Family Foster Care (licensed)	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Treatment Foster Care (TFC)	

Gender

Male Female Other (specify): _____

Court Case File Number(s) (if applicable)	Date Entered into Foster Care (If applicable)
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Race and Ethnicity (check all that apply)

<input type="checkbox"/> Asian	<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> White
<input type="checkbox"/> Black/African American	<input type="checkbox"/> Native Hawaiian/Pacific Islander	<input type="checkbox"/> American Indian/Alaska Native (specify Tribal affiliation):
<input type="checkbox"/> Other (specify): _____		

Primary Language/Mean of Communication	Age	Height	Weight
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Foster Care Payment Source (check one)

Title IV-E Regular Match Emergency Assistance Tribal IV-E Tribal 638 URM Out of State

Other Payment Source

SSI SSDI Voluntary Treatment Program N/A Other (specify): _____

If the child is not in public custody, has the child received Voluntary Treatment Program approval?

Yes No

ND Medicaid Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	ND Medicaid Number	Financially Responsible County
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Third Party Insurance <input type="checkbox"/> None <input type="checkbox"/> Yes (provide requested details)	Name of Insurance Policy Holder
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Insurance Policy Number	Name of Insurance Company	Telephone Number
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Address	City	State	ZIP Code
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INFORMATION SOURCES

Case Worker Name	Legal Custodian Agency Name	Case Worker Telephone Number
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Case Worker Email Address	Legal Custodian Type <input type="checkbox"/> HSZ <input type="checkbox"/> DJS <input type="checkbox"/> Tribe <input type="checkbox"/> Parent
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Name(s) of Parent(s) (if not in public custody)	Parent Email Address	Parent(s) Telephone Number
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Address	City	State	ZIP Code
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INFORMATION SOURCES (continued)

Information Sources to be Interviewed as part of the assessment, including: members of the Child and Family Team (CFT), treatment providers, parent/guardian involved in the child's case.

Name of Primary Support or Child & Family Team Member	Relationship to Child (mother, father, sibling, grandparent, guardian ad litem, foster care provider, teacher, treatment provider, therapist, case worker, school personnel, etc.)	Telephone Number	Email Address

Involvement: Describe each primary support's involvement in the child's treatment, giving specific examples.

SERVICES SOUGHT/REFERRAL TYPE

Services Sought/Referral Type Applying for (check all that apply)

- Family Foster -TFC (send to Maximus and TFC agency)
- Psychiatric Residential Treatment Facility (PRTF) (send to Maximus and PRTF)
- Qualified Residential Treatment Program (QRTP) Application/Initial Request (send to Maximus and QRTP)

Was the child placed as an emergent placement?

- Yes No - If no, is there a proposed admission date? No Yes - If yes, what is the date?

If the child was placed as an emergent placement complete the following:

Facility	
Admission Date	Anticipated Discharge Date

Will the child's assessment meeting (face-to-face) with the Qualified Individual be held in a location other than their current residence noted on page 1? Yes - list address below No

Address	City	State	ZIP Code
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The Assessment Outcomes Report will be sent by the Qualified Individual to the custodial case worker and to the court (if child is in public custody). The Qualified Individual must e-file, so the child's court number on page 1 is required before submission.

List the Court Where the Child's Case is Heard
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PLACEMENT HISTORY

Placement History (Beginning with the most current placement, describe the child's placement history)

Setting Type (e.g, TFC, QRTP, PRTF, Foster Care, Bio Home, etc.)	Provider (if applicable)	Start Date	End Date	Reason for Placement	Describe why the placement ended (provide details)

If the child is currently placed or approved to be placed in a treatment setting, explain in detail what the discharge plan is when treatment is no longer required.

REASON FOR REFERRAL AT THIS LEVEL OF CARE

Why are treatment services being sought now? Create a timeline providing details of pertinent events, within the last 90 days that led to this referral:

What are the **current** (last 90 days) behaviors or safety risks that require treatment placement for the child?

What current or recent services and supports have been attempted and implemented to help maintain the child in a family setting? Describe in detail why the services have been determined insufficient or ineffective.

If the child was placed in a Treatment Setting/Facility within the last six months please describe the aftercare efforts made by the agency and detail what community services and supports have been provided to the child and family and what about these services has not met need:

CHILD AND FAMILY STRENGTHS AND RESILIENCY FACTORS

- | | | |
|---|---|--|
| <input type="checkbox"/> Asks for support when needed | <input type="checkbox"/> Genuine interest in school | <input type="checkbox"/> Resilient |
| <input type="checkbox"/> Confident | <input type="checkbox"/> Hobbies | <input type="checkbox"/> Spirituality |
| <input type="checkbox"/> Cultural identity | <input type="checkbox"/> Optimism | <input type="checkbox"/> Talents/interests |
| <input type="checkbox"/> Empathetic | <input type="checkbox"/> School work/chores independently | <input type="checkbox"/> Vocational/work ethic |
| <input type="checkbox"/> Follows rules | <input type="checkbox"/> Social | <input type="checkbox"/> Other (describe): _____ |

Family Strengths

- Cultural identity Interpersonal Optimism Spirituality Talents/interests Vocational/work ethic Other

Describe in detail the child and family strengths identified above.

CHILD'S CURRENT AND CONSISTENT BEHAVIOR/SYMPTOMS This is specific to the past 90 days only. The custodian, parent or guardian must provide the recent progress notes and incident reports that support boxes checked below.
D=Daily; W=Weekly; M=Monthly

	D	W	M		D	W	M		D	W	M
Anxiety/Excessive worry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Danger/Violence to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fire setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexually abusive behaviors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Threatening behaviors or actions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Harm to animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual exploitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School refusal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Harm to self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School misbehavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal thoughts or statements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other: _____			
Intentional misbehavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other: _____			
Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Problems with authority/ Following rules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other: _____			
Self care/Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peer relationship issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runaway	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Property destruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								
Psychosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>								

Describe in detail the child's mental health diagnosis, Intellectual or Developmental Disability Diagnosis and medications.

In order to accept the application, the referral must attach details up to the past 90 days specific to:

- Recent discharge information (if previously placed in a facility/treatment setting);
- Assessment, testing, IEP, medication list, diagnosis detail, or specialist evaluations;
- Progress notes specific to therapeutic intervention.
- If the child was placed in a QRTP in the past 6 months attach all aftercare documentation.
- No previous history to share. Attach a narrative with any pertinent information known and detail why treatment is being requested.

By typing my name below, I am signing this document electronically. I agree that my electronic signature is the legal equivalent of my manual/handwritten signature. I agree that the electronic signature appearing on this document has the same validity and enforceability as a handwritten signature.

REFERRAL INFORMATION

Who completed the form?

- HSZ DJS Tribal Nation Parent/Guardian Other: _____

Name of Referrer	Referral Date
Email Address	Telephone Number

TREATMENT AGENCY ONLY:

- If the child was placed as an emergency placement, the treatment agency must submit the SFN 831 Children's Treatment Services Level of Care Determination Attestation and initial supporting documentation to Maximus within 48 hours of placement.