



UNIVERSAL APPLICATION
 DEPARTMENT OF HEALTH AND HUMAN SERVICES
 CHILDREN AND FAMILY SERVICES
 SFN 824 (9-2024)

Directions: This form is completed by the custodian (public agency worker or a parent or legal guardian if the 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 legal guardian must attach additional information to support the need for treatment. If referred by a **parent or legal guardian**, the completed form must first be submitted to the HHS screener.

*In compliance with the Federal Privacy Act of 1974, the disclosure of the social security number on this form is voluntary. They are not disclosed to the public. The numbers are used to maintain accurate files. Therefore, while voluntary disclosure is requested, failure to do so will not invalidate this application.

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, 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 service history: Attach a narrative detailing why treatment is being requested and why community services **have not** been sought.

CHILD DEMOGRAPHICS AND INFORMATION SOURCES

Last Name		Name (First, Middle Initial)		Date of Birth	
Current Residence Address			City	State	ZIP Code
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 <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (specify): _____			Age	Height	Weight
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): _____					
If in Public Custody, Court Case File Number(s)			If in Public Custody, Date Entered into Foster Care		
If in Public Custody, Foster Care Payment Source (check one)					
<input type="checkbox"/> Title IV-E <input type="checkbox"/> Regular Match <input type="checkbox"/> Emergency Assistance <input type="checkbox"/> Tribal IV-E <input type="checkbox"/> Tribal 638 <input type="checkbox"/> URM <input type="checkbox"/> Out of State					
Other Payment Source					
<input type="checkbox"/> SSI <input type="checkbox"/> SSDI <input type="checkbox"/> N/A <input type="checkbox"/> Other (specify): _____					
ND Medicaid Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		ND Medicaid Number		Social Security Number (If not on ND Medicaid)	
Third Party Insurance <input type="checkbox"/> None <input type="checkbox"/> Yes (provide requested details)		Name of Insurance Policy Holder			
Insurance Policy Number	Name of Insurance Company			Insurance Company Telephone Number	

INFORMATION SOURCES

Public Custody (Human Service Zone, DJS and Tribal Nations)		Private Custody (Parent/Legal Guardian)	
Case Worker AND Agency Name		Parent /Legal Guardian Name	
Telephone Number		Telephone Number	
Email Address		Email Address	

Information Sources: Individuals to be interviewed as part of the assessment including members of the Child and Family Team (CFT), treatment providers, parent/legal guardian involved in the child's case. Telephone number and email addresses are required. If one is not available indicate why in the boxes below:

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

Psychiatric Residential Treatment Facility (PRTF)

Qualified Residential Treatment Program (QRTP)

If working with a facility, what is the facility name:

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
---------	------	-------	----------

For children in public custody, the Assessment Outcomes Report will be sent to the custodial case worker and to the court. 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

PLACEMENT HISTORY

Describe where the child has resided for the past **6 months** (including the child's parental home, if applicable).
Begin with where the child is currently residing.

Setting (e.g. TFC, QRTP, PRTF, hospitalization, foster, parental 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 out of the home or approved to be placed in a treatment setting, explain in detail what the discharge plan is including **where the child will reside** 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 legal 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"/>	Suicide 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"/>								

If needed, provide further detail regarding the child's mental, intellectual or developmental diagnoses. In addition, list medications and/or assessment details not attached.

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. Parent or Legal Guardian signature is required for those who are not in public custody.

REFERRAL INFORMATION

Who completed the form?

- HSZ DJS Tribal Nation Parent/Legal Guardian Other: _____

Name of Referrer	Signature of Parent/Legal Guardian (if applicable)	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.