Admissions Fax: 877.470.1267
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Universal Residential Treatment Application

Incomplete applications may delay review and approval process.

Date of Application: _____ **Date Service Needed:** _____

Consumer Information

Consumer's Name: _____ Nickname: _____
Social Security Number: _____ Date of Birth:_____ Age:_____ Sex:_____
Medicaid Number:_____ Managing entity (*if applicable*):_____
Commercial insurance name and ID: _____ (*Please attach a copy of card/s*)
Consumer's Current Address:_____
Current Living Arrangement :_____
Place of Birth:_____ Race/s:_____ Primary Language: _____
Distinguishing Features (i.e., scars, tattoos, birthmarks, etc.): Weight: _____ Height:_____
_____

Guardian Information

Legal Guardian: _____
Relationship: _____ County of Legal Custody: _____
legal guardianship (through court system) must be in process before age 18, in place after age 18
Guardian's Address: _____
Guardian's Phone Number: _____ Cell:_____
Guardian's Email: _____
Emergency Contact: _____ Relationship to Consumer: _____
Contact #: _____ Additional Phone #: _____
Guardian ad litem name and phone (if applicable):
_____

Consumer Primary Referral Source Information:

Referring Agency: _____
Location:_____ Relationship:_____
Community Provider Agency: _____ Phone #: _____
Agency Contact Person: _____ Phone #: _____
Referral Email: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Clinical/Diagnostic Information:

DSM V

Diagnoses:	Effective Date:	Source:

Autism testing: ADOS/CARS testing date/s? (please attach) _____
Functional Level Scores:
IQ: _____ Verbal: _____ Performance: _____ Full Scale IQ: _____
Examiner: _____ Date: _____

Medication/s

Medication	Prescribing Physician	Dosage/Frequency	Date began/compliant?

Presenting Problems/Concerns, Reason for Referral

_____
_____
_____
_____
_____

Strengths/Abilities/Preferences

Strengths/Capabilities:

_____
_____
_____

Friendships/Social/Peer Support:

_____
_____
_____

Rewards/Motivations:

_____
_____
_____

Meaningful Activities (community involvement, volunteer activities, leisure recreation, other interests):

_____
_____
_____

Religion/Spirituality/Cultural/Ethnic Concerns:

_____
_____

Goals for Treatment:

_____
_____
_____
_____
_____

Previous Treatment Interventions (outpatient, inpatient, residential, group homes, etc.)

Provider/Location	Date(s)	Outcome

Current Emotional/Behavioral Problems

Home:_____
_____
School:_____
_____
Community:_____
_____

Are there identifiable/suspected triggers for behaviors?

☐ Sensory sensitivity
☐ Change in schedule or routine
☐ Escape a boring/difficult task
☐ Crowds
☐ Overstimulation
☐ Under-stimulation
☐ Denial of preferred activities/objects
☐ Being told "no"
☐ Other (please describe):

_____
_____

Please check applicable concerns:

☐ Abandonment Issues
☐ Anxiety
☐ Arson
☐ Alcohol/Drug Abuse
☐ Antisocial Behavior
☐ Stool/Feces smearing
☐ Assaultive (Physical)
☐ Assaultive (Sexual)
☐ Assaultive (Verbal)
☐ Bedwetting
☐ Eating Disorder
☐ Depression
☐ Property Destroying
☐ Fire Setter
☐ Developmental Disability
☐ Homeless
☐ Hyperactive
☐ Impulsive
☐ Lying
☐ Low Self-Esteem
☐ Loss/Grief Difficulties
☐ Physical Impairment
☐ Parent Neglect Issues
☐ Perception of Reality
☐ Phobic Behavior
☐ Physical Disability
☐ Self-Destructive Behavior
☐ Sibling Related Difficulty
☐ Oppositional
☐ Social Immaturity
☐ Sexually Inappropriate Behavior
☐ Stealing
☐ Suicidal
☐ Running Away
☐ Truancy
☐ Unruly/Ungovernable
☐ Cruelty to Animals
☐ Hygiene/Cleanliness Issues
☐ Problems with Sleep
☐ Repetitive Behaviors
☐ History w/ Weapons

Aggressive or Violent Behaviors

Please describe the nature of the 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?
_____
_____

Triggers (if known), Please Describe:
_____
_____

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

Please Describe the Most Recent Episode of Aggression:
_____
_____
_____
_____
_____
_____

History of Self-Injurious/ Maladaptive Behaviors

Self-Injury

Check all that apply:

☐ Head-banging

☐ Biting

☐ Other (please describe): _____

Has Self-Injury ever Required Medical Attention? ☐ Yes ☐ No (Please explain):

_____

Suicidal Characteristics

Check all that apply:

☐ Suicidal Thoughts ☐ Past Suicide Attempts

☐ Suicidal Plans (describe): _____

Methods Used in Previous Attempts (describe): _____

Were Attempts Planned: ☐ Yes ☐ No ☐ Sometimes ☐ Don't know

Homicidal Characteristics

Check all that apply:

☐ Homicidal Thoughts ☐ Past Attempts to Harm Others

☐ Homicidal Plans (describe): _____

Methods Used in Previous Attempts (please describe): _____

Were Attempts Planned: ☐ Yes ☐ No ☐ Sometimes ☐ Don't know

Does Consumer have Access to Weapons? ☐ Yes ☐ No

Please Explain: _____

History of AWOL

Runs Away from Home: ☐ Yes ■ No

Has Run from Previous Placements: ☐ Yes ■ No

In the Past Year how Many Times has Consumer Run? _____

Where Does He/She Go? _____

How Long is Consumer Typically AWOL? _____

Substance Use History

Circle all that apply:

☐ Marijuana
☐ Cocaine
☐ Heroin/Opiates
☐ Amphetamines
☐ Inhalants
☐ Hallucinogens
☐ Alcohol
☐ Tobacco

Other: _____

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:
_____
_____
_____
_____

Medical Information

Allergies: _____

Special Dietary Needs: _____

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

☐ High cholesterol
☐ Cerebral Palsy
☐ Eczema
☐ Anemia
☐ GERD
☐ Asthma
☐ Fetal Alcohol Syndrome
☐ Vitamin deficiency
☐ Vision loss
☐ HIV/AIDS
☐ Sleep Apnea
☐ Seizures
☐ Sexually Transmitted Disease
☐ Chicken Pox
☐ Sinus Problems
☐ Thyroid disease
☐ Sickle Cell Anemia
☐ Diabetes
☐ Tuberculosis
☐ Migraine Headaches
☐ Hepatitis
☐ Chronic Urinary/Bowel Problems
☐ Hypertension
☐ TBI

Other (ex: feeding problems, chromosomal disorders & other genetic conditions):
_____
_____

Name and Number of Pediatrician: _____
Name and Number of Dentist: _____
Date of Last Physical Exam: _____ Last Dental Exam:_____ Last Eye Exam: _____
Dental Appliances: ☐ Yes ☐ No Contacts/Glasses: ☐ Yes ☐ No

Medical Insurance Company: ☐ Commercial ☐ Medicaid ☐ Other _____
Private Ins.(Agency): _____
Insurance Policy Number: _____
Subscriber name/DOB? _____ ____
(Please attach a copy of ALL insurance card/s.)

History of Abuse/Neglect

If checked please provide a written description. If DSS involvement, please attach documentation.

☐ Victim of Neglect: _____

☐ Victim of Physical Abuse: _____

☐ Victim of Sexual Abuse: _____

☐ Victim of Emotional Abuse: _____

☐ None

Family Information

Mother's Name:_____

Address: _____

Telephone Number: Home: _____Work:_____Cell:_____

Ethnicity: _____ Education Level: _____ (Unknown ☐)

Criminal Record: ☐Yes ☐No ☐Unknown

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	Description of Relationship

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

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

Explain: _____

School Information

Last School Enrolled: _____ District: _____

Previous Enrollments: _____

Grade: _____ Special Classes: ☐ED ☐LD ☐Resource ☐BEH ☐Homebound ☐Other: _____

Any History of Truancy? ☐ Yes ☐ No Grade(s) Repeated: _____

Current IEP? ☐ Yes ☐ No

Suspensions/Expulsions: _____

Family Social History

Include description of social history, and significant family events leading up to referral, and living arrangement prior to referral. If checked, then please explain.

☐ Criminal Activity
☐ Child Abuse
☐ Inappropriate Sexual Behavior
☐ Treatment Disruption
☐ Psychiatric Illness
☐ Substance Abuse
☐ Suicide
☐ Other:

_____
_____
_____
_____
_____
_____

(If other pertinent family history, then please document separately and attach.)

Authorized Contacts/Resources for continuity of care

Please include individuals you wish to be included in therapeutic process

Name	Relationship	Address	Telephone Number	Types of Contact (visitation, telephonic, written, etc.)

Special Conditions/Restrictions for Home Visits?_____
_____

Agency/Provider Involvement

Indicate all agencies currently involved:

☐ Social Services ☐ Dept. of Mental Health ☐ DJJ ☐ Disability/special needs organization
☐ Other: _____

Case Manager(s) Contact Information (if applicable): _____
_____
_____

Court History

Does Consumer Have a Criminal Record? ☐ Yes ☒ No

Offenses	Conviction Dates	Tried as Juvenile or Adult

Pending Charges: _____

Is Consumer on Probation? ☐ Yes ☐ No Name and Contact: _____

Has Placement been recommended by Court? ☐ Yes ☐ No (If yes, please attach court order.)

Additional information:_____

_____

_____

_____

Final Comments

Desired Length of Stay*:

Acute: ☐ 28 day

PRTF (residential): ☐ 90 Days ☐ 180 Days ☐ 270 Days ☐ 360 Days

Anticipated Discharge Plan: ☐ Home with ABA, OP Medication Management + therapy ☐ Intensive in Home

☐ Therapeutic Foster Care ☐ Group Home ☐ Independent Living

_____

_____

_____

_____

_____

_____

_____

_____

_____

please note length of stay can be affected by insurance coverage

Signatures (*please sign as applicable*):

Legal Guardian	Print Name	Date
Referring Agency	Print Name	Date
Other Team Member	Print Name	Date
Care Coordinator	Print Name	Date

SUBMIT FORM