UNIVERSAL APPLICATION

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

Clear Fields

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

Current Residence Address	City	State	ZIP Code

Child's Current Living Arrangement (or type - e.g., home, foster home, etc.)

- ☐ Family Setting (parents)
- ☐ Family Setting (relatives) (specify): _____
- ☐ Family Foster Care (licensed)
- ☐ Treatment Foster Care (TFC)
- ☐ Qualified Residential Treatment Program (QRTP)
- ☐ Psychiatric Residential Treatment Facility (PRTF)
- ☐ Other (specify): _____

Gender

☐ Male ☐ Female ☐ Other (specify):

Court Case File Number(s) (if applicable)	Date Entered into Foster Care (If applicable)

Race and Ethnicity (check all that apply)

- ☐ Asian
- ☐ Black/African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ American Indian/Alaska Native (specify Tribal affiliation):
- ☐ Other (specify):

Primary Language/Means of Communication	Age	Height	Weight

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	ND Medicaid Number	Financially Responsible County
☐ Yes ☐ No ☐ Unknown		

Third Party Insurance	Name of Insurance Policy Holder
☐ None ☐ Yes (provide requested details)	

Insurance Policy Number	Name of Insurance Company	Telephone Number

Address	City	State	ZIP Code

INFORMATION SOURCES

Case Worker Name	Legal Custodian Agency Name	Case Worker Telephone Number

Case Worker Email Address	Legal Custodian Type ☐ HSZ ☐ DJS ☐ Tribe ☐ Parent

Name(s) of Parent(s) (if not in public custody)	Parent Email Address	Parent(s) Telephone Number

Address	City	State	ZIP Code

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

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

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

- ☐ Asks for support when needed
- ☐ Confident
- ☐ Cultural identity
- ☐ Empathetic
- ☐ Follows rules
- ☐ Genuine interest in school
- ☐ Hobbies
- ☐ Optimism
- ☐ School work/chores independently
- ☐ Social
- ☐ Resilient
- ☐ Spirituality
- ☐ Talents/interests
- ☐ Vocational/work ethic
- ☐ 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
Anxiety/Excessive worry	☐	☐	☐
Danger/Violence to others	☐	☐	☐
Threatening behaviors or actions	☐	☐	☐
School refusal	☐	☐	☐
School misbehavior	☐	☐	☐
Intentional misbehavior	☐	☐	☐
Impulsivity	☐	☐	☐
Self care/Hygiene	☐	☐	☐
Depression	☐	☐	☐
Property destruction	☐	☐	☐
Psychosis	☐	☐	☐

	D	W	M
Physical aggression	☐	☐	☐
Fire setting	☐	☐	☐
Harm to animals	☐	☐	☐
Harm to self	☐	☐	☐
Suicidal thoughts or statements	☐	☐	☐
Suicidal attempts	☐	☐	☐
Problems with authority/ Following rules	☐	☐	☐
Peer relationship issues	☐	☐	☐
Runaway	☐	☐	☐

	D	W	M
Panic attacks	☐	☐	☐
Sexually abusive behaviors	☐	☐	☐
Sexual exploitation	☐	☐	☐
Substance use	☐	☐	☐

- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

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 <u>90 days</u> 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.