



UNIVERSAL APPLICATION
 NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
 CHILDREN AND FAMILY SERVICES
 SFN 824 (5-2021)

Directions: This form is completed by the custodian (public agency case manager or a parent 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 must attach additional information to determine placement and best meet the needs of the child. This form must be submitted to the treatment provider (first) and the Qualified Individual, Ascend, only if applying for a QRTP.

CHILD DEMOGRAPHICS AND INFORMATION SOURCES

Last Name		Name (First, Middle Initial)		Date of Birth	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other (specify): _____			FC Case Number (FRAME)		
Court Case File Number(s)					
Race and Ethnicity (check one) <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
Eligibility: Check all that apply <input type="checkbox"/> Title IV-E <input type="checkbox"/> Emergency Assistance <input type="checkbox"/> SSI <input type="checkbox"/> SSDI <input type="checkbox"/> Unknown					
ND Medicaid Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			ND Medicaid Number		
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		Telephone Number		
Address		City	State	ZIP Code	

Date Entered into Foster Care	Age at Entry Into Foster Care	Financially Responsible County/Zone			
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"/> Family Foster Care - Therapeutic/Treatment (TFC)					

INFORMATION SOURCES

Case Manager Name		Legal Custodian Agency Name		Case Manager Telephone Number	
Case Manager Email Address				Case Manager Fax Number	
Name(s) of Parent(s) (if not in public custody)		Legal Custodian Type <input type="checkbox"/> DJ <input type="checkbox"/> County <input type="checkbox"/> Tribe <input type="checkbox"/> Parent		Parent(s) Telephone Number	
Address		City	State	ZIP Code	

INFORMATION SOURCES (continued)

Include on this chart primary supports or Child and Family Team (CFT) members who are involved in the child's case plan.

Name of Primary Support or Child & Family Team Member	Relationship to Child (mother, father, sibling, grandparent, guardian ad litem, foster parent, teacher, etc.)	Telephone Number	Involvement 1 = Minimal 2 = Inconsistent 3 = Involvement Pending 4 = Consistent with Limited Engagement 5 = Consistent and Engaged	Types of Supports C = Calls L = Letters V = Visits O = Other (describe)

Involvement - If rated 1,2,3, or 4 above, describe each primary support's involvement in further detail, giving specific examples.

SERVICES SOUGHT/REFERRAL TYPE

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

Family Foster -TFC (send to TFC agency)

Psychiatric Residential Treatment Facility (PRTF) (send to PRTF)

Qualified Residential Treatment Program (QRTP) Application/Initial Request (send to Ascend and Facility)

If QRTP was selected: Provide name(s) of QRTP facility this application was also submitted to:

Facility	Facility	Facility
QRTP Admission Date	Date if Already Admitted as an Emergency Placement	
Proposed Admission Date	Anticipated Discharge Date	

Will the child's QRTP 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 QRTP Assessment Outcomes Report will be sent by the Qualified Individual to the custodial case manager 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 to End Dates	Reason for Placement	Treatment Plan Completed?	Describe why the placement ended (provide details)
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

If the child is placed in a treatment setting, explain in detail the child's discharge plan:

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 behaviors or safety risks (last 30 days) that require treatment placement for the child?

What services and supports would be necessary for the child to remain in a family setting?

Why is a least restrictive treatment option insufficient to meet the child's needs?

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

SOCIAL AND ECONOMIC RISK FACTORS

- | | |
|--|--|
| <input type="checkbox"/> Abuse history (emotional, physical, sexual) victim | <input type="checkbox"/> Divorce |
| <input type="checkbox"/> Acculturation difficulty (e.g. refugee status) | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> Adopted | <input type="checkbox"/> Employment instability |
| <input type="checkbox"/> Homeless | <input type="checkbox"/> Family discord |
| <input type="checkbox"/> Unsafe Neighborhood | <input type="checkbox"/> Poverty/inadequate finances |
| <input type="checkbox"/> Substance use by parents or primary support | <input type="checkbox"/> Unstable Illness |
| <input type="checkbox"/> Abandonment by parents or primary support | <input type="checkbox"/> Neglect by parents or primary support |
| <input type="checkbox"/> Birth of a sibling | <input type="checkbox"/> Remarriage of a parent |
| <input type="checkbox"/> Exposure to disaster/war(describe): _____ | <input type="checkbox"/> Removal from home |
| <input type="checkbox"/> Death of a family member or primary support (describe): _____ | <input type="checkbox"/> Family incarceration/conviction(s) |
| _____ | |
| <input type="checkbox"/> Other (describe): _____ | |

CHILD'S CURRENT AND CONSISTENT BEHAVIOR/SYMPTOMS This is specific to the past 30 days only. Provide only the recent progress notes and incident reports.

List mental health, intellectual, developmental and substance related diagnosis. D=Daily; W=Weekly; M=Monthly

	D	W	M		D	W	M		D	W	M
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Property destruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Danger/violence to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fighting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual exploitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Threatening behaviors or actions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School Refusal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Harm to animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other: _____			
School Misbehavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Harm to self	<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 threats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other: _____			
Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diagnosis: _____			
Self care/Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Delinquent behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diagnosis: _____			
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peer relationship issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diagnosis: _____			

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

- Child and family team meeting notes or most recent permanency plan/case (if in public custody);
- Any recent discharge information (if previously placed in a facility/treatment setting);
- Any assessment, testing, IEP, medication list, diagnosis detail, or specialist evaluations;
- Any progress notes specific to therapeutic intervention.
- No previous history to share. Attach a narrative with any pertinent information known and detail why treatment is being requested.

REFERRAL INFORMATION

Who completed the form?

- Case Manager Parent Other: _____

Name of Referrer		Referral Date
Email Address	Telephone Number	Fax Number