Consumer Name
MID#

Community Specialized Services, Inc.

UNIVERSAL SERVICES APPLICATION

Date of Application _____ Date Service Needed: _____

Type of Referral:

- ☐ **Planned and Emergency Respite**
- ☐ **Residential Family Foster Care**
- ☐ **Residential Level 2- Therapeutic Foster**
- ☐ **Integrated Care Services Collaborative Care Model**

1. CONSUMER INFORMATION

Consumer's Name: _____Nickname: _____

Social Security Number: _____ Date of Birth:_____ Age: _____ Sex_____

Medicaid Number:_____ County: _____ Weight:_____ Height:_____

Consumer's Current Address: _____

Consumer's Phone Number: _____ Current Living Arrangement _____

Place of Birth: _____Primary Language_____

Distinguishing Features (i.e., scars, tattoos, birthmarks, etc.): _____

_____

2. GUARDIAN INFORMATION

Legal Guardian _____

Relationship: _____County of Legal Custody: _____

Guardian's Address: _____

Guardian's Phone Number:_____

If a Guardian ad Litem has been appointed please list Name and contact number:_____

_____

3. CONSUMER'S PRIMARY REFERRAL SOURCE INFORMATION

Referring Agency: ☐ Community Support ☐ DJJ ☐DSS County: _____

Other: _____

Provider Agency: _____ Phone #:_____

Agency Contact Person:_____ Phone #_____

Address: _____City/State/Zipcode:_____

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Emergency Contact Person: _____**Relationship to Client**_____

Telephone: _____ **Pager/Cell:** _____ **Fax:** _____

Address: _____

4. CLINICAL/DIAGNOSTIC INFORMATION

DSM IV-TR Multi-Axial Diagnosis

Diagnoses :	Date :	Source:
Axis I		
Axis II		
Axis III		
Axis IV		
Axis V		

Calocus Score:

IQ: _____ **Verbal** _____ **Performance**_____ **Full Scale** _____

Examiner: _____ **Date:** _____

History of Abuse: ☐ **Victim of Neglect** ☐ **Victim of Physical Abuse**
☐ **Victim of Sexual Abuse** ☐ **Victim of Emotional Abuse**
☐ **None**

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

Medications	Prescribing Physician	Dosage/Frequency	Date Started / Compliant?

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5. MEDICAL INFORMATION

Allergies:_____

Special Dietary Needs: _____

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

☐ **Lice**	☐ **Bulimia**	☐ **Eczema**
☐ **Anemia**	☐ **Anorexia**	☐ **Asthma**
☐ **Drug/Alcohol Abuse**	☐ **Measles**	☐ **Hay Fever**
☐ **HIV/AIDS**	☐ **Mumps**	☐ **Convulsions**
☐ **Sexually Transmitted Disease**	☐ **Chicken Pox**	☐ **Sinus Problems**
☐ **Ringworm**	☐ **Sickle Cell Anemia**	☐ **Diabetes**
☐ **Tuberculosis**	☐ **Migraine Headaches**	☐ **Hepatitis**
☐ **Chronic Urinary / Bowel Problems**	☐ **Rubella**	☐ **Traumatic Brain Injury**
Other:_____	**Other:**_____	**Other:**_____

Name and Address of Primary Care Physician:_____

Name and Address of Dentist: _____

Date of Last Phys. Exam:_____ **Last Dental Exam:**_____ **Last Eye Exam:**_____

Dental Appliances: ☐ **Yes** ☐ **No** **Contacts/Glasses:** ☐ **Yes** ☐ **No**

Medical Insurance Company: **Medicaid** _____ **NC Healthchoice** _____

Private Ins.(Agency) _____

Insurance Policy Number: _____

Insurance is in whose name? _____

Any other third party insurance? _____

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6. STRENGTHS/ABILITIES/PREFERENCES

Strength/Capabilities _____

_____

Friendships/Social/Peer Support Relationships: _____

_____

Religion/Spirituality: _____

Cultural/Ethnic Issues/Information/Concerns: _____

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

_____

Goals for Independent Living: _____

_____

7. PRESENTING PROBLEMS / REASON FOR REFERRAL

8. PREVIOUS TREATMENT INTERVENTIONS

Outpatient Intervention	Date	Effectiveness

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9. PLACEMENT HISTORY

Placement (Begin w/Current Placement)	Dates (From – To)	Reason for Discharge

10. CURRENT EMOTIONAL / BEHAVIORAL PROBLEMS

Please describe behavior and include the date of last incident.

☐ **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**	☐ **Mental Retardation**	☐ **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**	☐ **Gang Related Activity**	☐ **History w/ Weapons**

Other_____

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AGGRESSIVE OR VIOLENT BEHAVIOR ALERT

Please describe the nature of the acting out 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:_____

Known triggers, please describe:
_____
_____
_____
_____

Main targets of aggression: □ Peers □ Authority figures □ Family members Please be specific:

Please describe the most recent episode of aggression:

11. FAMILY INFORMATION

Biological Mother's Name:_____

Address:_____

Telephone Number: Home: _____**Work:** _____**Cell:**_____

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Ethnicity _____ Educ. Level: ___ Unknown ____ Criminal Record: _____(Yes/No) Unknown _____

Biological Father's Name:_____

Address:_____

Telephone Number: Home: _____Work: _____Cell:_____

Ethnicity _____ Educ. Level: ___ Unknown ____ Criminal Record: _____(Yes/No) Unknown

Are Parents: ☐Married ☐Separated ☐Divorced ☐Never Married ☐ Deceased Mother ☐ Deceased Father

Have parental rights been terminated: _____ If so, who and when? _____

How many siblings does Consumer have: _____

Age	Gender	Name	Age	Gender	Name
Age	**Gender**	**Name**	**Age**	**Gender**	**Name**

Are siblings in out-of-home placements? _____

If yes, please specify: ☐DSS Foster Care ☐Relatives

☐Incarcerated ☐Group Home

Other: _____

12. FAMILY DYNAMICS / FAMILY SOCIAL HISTORY

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

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

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If other pertinent family history please document separately and attach.

13. AUTHORIZED CONTACTS

Name	Relationship	Address	Telephone Number	Types of Contact With Client (supervised, letter, etc.)	Date of Release of Information

Are there any special conditions/restrictions for visits home?_____

_____

Any "no contact" orders? _____

_____

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14. SCHOOL INFORMATION

Last School Enrolled: _____ _____

District: _____ **Grade:** _____

Special Classes: ☐EH ☐LD ☐Resource ☐BEH _____
☐Homebound **Other:** _____

Any history of truancy? _____ **Grades Repeated:** _____

Current IEP? ☐Yes ☐No **Date:** _____

Suspensions/Expulsions: _____

15. AGENCY INVOLVEMENT

Indicate all agencies currently involved:

☐DSS ☐ Mental Health Provider _____

☐DJJ ☐Voc Rehab **Other:** _____

16. COURT HISTORY

Does Consumer have a criminal record? ☐Yes ☐ No

Offenses	Conviction Dates	Tried as Juvenile Or Adult
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pending Charges: _____

Is Consumer on Probation?_____ **Name and Contact #of Court Official**_____

Is placement court ordered? ☐Yes ☐No **(If "Yes, attach court order)**

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17. TREATMENT GOALS

Please attach copy of Person Centered Plan/ Individual Support Plan (if applicable) that includes service being requested.

18. HISTORY OF SELF-INJURY AND RISK BEHAVIORS

Self Injury	**Check all that apply ☐ cuts on body ☐ conceals cutting- indicate area** **☐other forms of self injury (please describe)** **Has self-injury ever required medical attention? Please explain:**
Suicidal Characteristics	**Check all that apply ☐Suicidal thoughts ☐ Past Suicide Attempts ☐ Suicidal Plans** **Describe:** **Methods used in previous attempts- please 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? Please explain**
History of AWOL	**☐ Runs away from home** **☐ Has run from previous placements** **In the past year how many times has consumer run? ____** **Where does he/she go? _____** **How long is typically AWOL? _____**

Substance Abuse History

Type of Substance	Frequency	Last Use	Type of Substance	Frequency	Last Use
☐ Marijuana			☐ Amphetamines		
☐ Cocaine			☐ Hallucinogens		
☐ Heroin/Opiates			☐ Alcohol		
☐ Inhalants			☐ Other:		

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Sexualized Behaviors	**Please describe any sexualized behaviors exhibited by consumer (i.e. exposure, sexual acting out, predatory behaviors, prostitution)**
Psychotic Behaviors	**Please describe any past/present history of psychosis**

19. ADDITIONAL COMMENTS

Please use this space to include any additional comments that may support this application

20. REFERRAL CHECKLIST

In 2nd column please indicate each item that is being attached to this packet. Please comment on reasons items are missing or items that will be sent at later time.

Universal Application	
Person Centered Plan / Sign Page	
Discharge Summaries from Hospitalizations/ Previous Treatment	
Consent to exchange information	
School Records/ IEP	
DSS records (if applicable)	
DJJ records (if applicable)	

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Psychological Testing	
Sexually Aggressive Youth Evaluation / Sex Offender Specific Evaluation	
Immunization Records	
Birth Certificate	
Copy of Medicaid/ Insurance Cards	
Psychiatric evaluations	
Diagnostic Assessment (or any other assessment completed)	
Treatment Authorization Request	
Court/Custody Orders	

21. SIGNATURES

Legal Guardian **Date**

Treatment Service Coordinator Signature **Date**

Supervisor Approval **Date**

Clinical Approval **Date**

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