Vaya Health

Universal Residential Placement Application

Instructions for completion:

Consistent with System of Care principles, the Universal Child and Adolescent Residential Application offers a comprehensive clinical review of a member's needs for purposes of admission to a residential provider contracted with Vaya Health. Please follow the instructions below:

1. This application, including all sections, must be completed in its entirety. Answer each question, indicating "N/A" if not applicable. Applications may be returned to referring party if deemed incomplete.
2. Do not enter "see attached" in sections requiring specific detail. If you have a document that provides greater detail than can be entered, reference the document name, date and page number at the end of your explanation. (e.g., Physical Assessment, 07.01.15, page 3). Submit any reference documentation along with this application.
3. The person completing this application is responsible for obtaining necessary releases/authorizations to disclose protected health information.
4. The Universal Application must be signed by the legally responsible person as defined at N.C.G.S. § 122C-3(20): "a parent, guardian, a person standing in loco parentis, or a legal custodian other than a parent who has been granted specific authority by law or in a custody order to consent for medical care, including psychiatric treatment."

Disclaimer: This form was created for the convenience of referring agencies/ individuals to streamline discharge planning and eliminate time and redundancy associated with multiple agency-specific applications. Use of this form does not, and should not be construed to, guarantee authorization of residential or other treatment by Vaya. Moreover, responsibility for appropriate discharge from inpatient facilities remains with the discharging provider.

Date of application: ___________________________ **Date service needed:** ___________________________

Type of referral/Level of Care sought:

- ☐ Residential Level I – Family type
- ☐ Residential Level II – Family type
- ☐ Residential Level II – Program type
- ☐ Residential Level III – Group home
- ☐ Residential Level IV – Secure
- ☐ Psychiatric Residential Treatment Facility (PRTF)
- ☐ Emergent Need Respite – Internal referrals only
- ☐ Residential Supports, Alternative Family Living (AFL) – Innovations Waiver
- ☐ Residential Supports, Group home – Innovations Waiver
- ☐ Non-Medicaid-Funded Residential Services – Group home or AFL
- ☐ Long-Term Community Support – Intellectual/developmental disability (IDD) Residential Services (Medicaid)
- ☐ Individual Supports – Mental health (Medicaid)
- ☐ Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID)

Member name: ____

Medicaid ID#: ____

Universal Residential Placement Application

1. MEMBER DEMOGRAPHIC INFORMATION

Member name: ______________________________ **Nickname:** ______________________

Date of birth: ____________ **Age:** ____ **Sex:** ☐ Male ☐ Female **Race:** ______________

Place of birth: ______________________________ **Primary language:** ______________

SSN: ______________ **Medicaid #:** ______________ **County of residence:** ______________

Member's current address: ____

Member's phone number: __________________________

Current living arrangement: ____

2. LEGALLY RESPONSIBLE PERSON INFORMATION

Is the minor under the care and custody of his or her parent? ☐ Yes ☐ No **(If yes, skip to next section.)**

Is there a legal guardian/legal custodian appointed by a court of competent jurisdiction? ☐ Yes ☐ No
(If yes, attach copy of court order.)

Name of guardian/custodian: ____

Relationship to member: ______________________ **County of legal custody:** ______________

Mailing address: ____

CONTACT INFORMATION:

Home phone: ______________ **Work phone:** ______________ **Cell phone:** ______________

Is there an individual acting *in loco parent*is (such as another relative)? ☐ Yes ☐ No
(If yes, explain circumstances under which individual is acting *in loco parentis*.)

____

Name of individual: ______________________ **Relationship to member:** ______________

Mailing address: ____

CONTACT INFORMATION:

Home phone: ______________ **Work phone:** ______________ **Cell phone:** ______________

3. FAMILY INFORMATION

Biological parents are: ☐ Married ☐ Separated ☐ Divorced ☐ Never married ☐ Deceased mother ☐ Deceased father

Have parental rights been terminated? ☐ Yes ☐ No

If so, by whom and when? ____

Is the member adopted? ☐ Yes ☐ No ☐ Check here if information pertaining to biological parents is unknown.

Biological mother's name: ____

Address: ____

Phone numbers: **Home:** ____________________ **Work:** ____________________ **Cell:** ____________________

Date of birth: ____________________________ **Race:** _____________________

Biological father's name: ____

Address: ____

Phone numbers: **Home:** ____________________ **Work:** ____________________ **Cell:** ____________________

Date of birth: ____________________________ **Race:** _____________________

Sibling or other significant relationship:

Name: ____________________________________ **Home phone:** __________________ **Cell phone:** ____________________

Address: ____

Additional sibling or other significant relationship:

Name: ____________________________________ **Home phone:** __________________ **Cell phone:** ____________________

Address: ____

Are any "no contact" orders currently in place? ☐ Yes ☐ No

Describe: ____

Are any special conditions/restrictions for home visits in place? ☐ Yes ☐ No

Describe: ____

4. FAMILY DYNAMICS/FAMILY SOCIAL HISTORY

Include description of family dynamics, family history and significant family events leading up to referral, living arrangement prior to referral and, if removed from family of origin, the circumstances that led to that event.

If other pertinent family history exists, please document separately and attach.

5. REFERRAL SOURCE INFORMATION

Referring agency: ☐ Hospital ☐ Clinical home agency ☐ DJJ ☐ DSS County: ____________________________

Other: ____

Name of referring agency: ____

Contact person: _______________________________ **Phone number:** ___________________________________

Alternate contact number: _______________________________ **Fax number:** ___________________________________

6. PRESENTING PROBLEM/REASON FOR REFERRAL

7. CLINICAL/DIAGNOSTIC INFORMATION

DSM V – DIAGNOSTIC INFORMATION

CODE	DIAGNOSIS

CALOCUS score: ____________ **Has member received a psychological evaluation?** ☐ Yes ☐ No **If yes, when?** ____________

Examiner: ____ **Exam date:** ___________________

Is the member diagnosed with an intellectual/developmental disability? ☐ Yes ☐ No

If yes, list the Full Scale Intellectual Quotient (FSIQ): __________ **Examiner:** ______________________ **Date:** ______________

If yes, list the adaptive scores: ___________________________ **Examiner:** ______________________ **Date:** ______________

8. MEDICATION INFORMATION

☐ **MEDICATION LIST ATTACHED** *(If list attached, it is not necessary to complete this section.)*

MEDICATION	DOSE/ROUTE	FREQUENCY	INDICATION

9. TREATMENT AND PLACEMENT HISTORY

Treatment/placement history (begin with most current intervention)	Dates (from – to)	Reason for discharge

10. CURRENT SYMPTOMS/OBSERVATIONS

Check all that apply. Provide specific details and/or the date of last incident, if known and applicable.

☐ Abandonment issues ___	☐ Anxiety ___	☐ Arson/fire-setting ___
☐ Stool/feces smearing ___	☐ Physical aggression ___	☐ Verbal aggression ___
☐ Bedwetting ___	☐ Eating disorder behaviors ___	☐ Depression ___
☐ Property destruction ___	☐ Homelessness ___	☐ Hyperactivity ___
☐ Impulsivity ___	☐ Lying ___	☐ Low self-esteem ___
☐ Loss/grief ___	☐ Phobias ___	☐ Sibling-related difficulty ___
☐ Oppositional ___	☐ Social immaturity ___	☐ Stealing ___
☐ Truancy ___	☐ Cruelty to animals ___	☐ Hygiene/cleanliness issues ___
☐ Problems with sleep ___	☐ Gang-related activity ___	☐ History with weapons ___

Abuse/trauma history: ☐ None ☐ Victim of neglect ☐ Victim of physical abuse ☐ Victim of sexual abuse ☐ Trauma

If checked, provide a brief description:

11. RISK ASSESSMENT

☐ **Self–injurious behavior**	**Check all that apply:** ☐ Cuts on body ☐ Conceals cutting (*indicate area:* ________) ☐ Other forms of self-injury (*describe:* ________) **Has self-injury ever required medical attention?** ☐ Yes ☐ No **Explain:** ________
☐ **Suicidal characteristics**	**Check all that apply:** ☐ Suicidal thoughts ☐ Past suicide attempts ☐ Suicidal plans **Describe:** ________ **Describe methods used in previous attempts:** ________ **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:** ________ **Describe methods used in previous attempts:** ________ **Were attempts planned?** ☐ Yes ☐ No ☐ Sometimes ☐ Don't know **Does the member have access to weapons?** ☐ Yes ☐ No **Explain:** ________
☐ **History of elopement**	**Check all that apply:** ☐ Runs away from home ☐ Has run from previous placements **In the past year, how many times has the member run away?** ________ **Where does he/she go?** ________ **How long is he/she typically away from home/placement?** ________
☐ **Sexualized behaviors**	**Check all that apply:** ☐ Sexual acting-out ☐ Deviant sexual behavior ☐ Sexual exploitation ☐ Other *(describe)*: ________
☐ **Psychotic symptoms**	**Check all that apply:** ☐ Auditory hallucinations ☐ Visual hallucinations ☐ Delusions ☐ Other *(describe)*: ________

12. SUBSTANCE USE INFORMATION ☐ *N/A – Proceed to next section*

TYPE OF SUBSTANCE	ROUTE	FREQUENCY	LAST USE
☐ Alcohol			
☐ Amphetamines			
☐ Cocaine			
☐ Hallucinogens			
☐ Heroin/opiates			
☐ Inhalants			
☐ Marijuana			
☐ Nicotine/e-cigs/Juuls			
☐ Benzodiazepines/hypnotics			
☐ Other: ___________________________			

13. MEDICAL INFORMATION

Weight: ____________________ **Height:** ____________________ **Date of last physical exam:** ____________________

Allergies: ____ **Drug allergies:** ____

Special dietary needs: ____

Immunization status: ☐ Current ☐ Delayed ☐ Refused

MEDICAL CONDITIONS (PAST AND PRESENT)

Most recent occurrence: ____

☐ Acne ☐ Diabetes ☐ HIV/AIDS ☐ Sexually transmitted disease
☐ Anemia ☐ Eczema/rash ☐ Migraine/headaches ☐ Sickle cell anemia
☐ Asthma ☐ Hepatitis ☐ Seizures/epilepsy ☐ Thyroid disease
☐ Chronic urinary/bowel problems

☐ Other: ____ ☐ Other: ____

☐ Other: ____ ☐ Other: ____

Name/address of pediatrician: ____

Date of last dental exam: _____________________ **Dental appliances:** ☐ Yes ☐ No

Name/address of dentist: ____

Date of last eye exam: _____________________ **Corrective lenses:** ☐ Yes ☐ No **Type:** ___________________

Name/address of eye doctor: ____

14. INSURANCE COVERAGE

Health insurance coverage: ☐ Medicaid ☐ N.C. Health Choice ☐ Medicare ☐ TRICARE ☐ N.C. State Health Plan

☐ Private health insurance ☐ Other: ____

Insurance policy number: _________________________________ **Group number:** _______________________________

Name of policy holder: ____

Other third-party insurance? ____

15. AGENCY INVOLVEMENT

Indicate agencies currently involved. Check all that apply:

☐ **Vaya care coordinator** Name: ____ Phone: ______________________

☐ **DSS County:** ______________ Social worker: __________________________________ Phone: ______________________

☐ **Clinical home provider** Name: ____ Phone: ______________________

☐ **Guardian ad Litem (GAL)** Name: ____ Phone: ______________________

☐ **DJJ court counselor** Name: ____ Phone: ______________________

☐ **Other:** ___________________ Name: ____ Phone: ______________________

☐ **Other:** ___________________ Name: ____ Phone: ______________________

16. EDUCATIONAL/SCHOOL INFORMATION

Last school enrolled: ____

District: ____ **Highest grade level completed:** __________

Current IEP? ☐ Yes ☐ No **Date:** __________________ **Grade(s) repeated:** ______________________

Special classes: ☐ EC ☐ LD ☐ Resource ☐ BED ☐ Homebound ☐ Other: ______________________

Suspensions or expulsions: ____

17. LEGAL HISTORY

☐ ***N/A – Proceed to next section***

Does the member have a criminal record? ☐ Yes ☐ No **Is the member on probation?** ☐ Yes ☐ No

Are there pending charges? ☐ Yes ☐ No **Charge(s):** ____

List brief description of prior offenses and conviction dates (if known):

____

Attach any court orders applicable to this member.

18. DAILY LIVING SKILLS INFORMATION *(Required for IDD and co-occurring IDD/MH referrals)*

EATING:

Does the member eat solid foods? ☐ Yes ☐ No *If no, explain:* ____________________

Does the member eat independently? ☐ Yes ☐ No *If no, explain:* ____________________

Does the member require special accommodations? ☐ Yes ☐ No *If yes, explain:* ____________________

Is there a history of choking/overfilling mouth? ☐ Yes ☐ No

TOILETING:

Is the member continent? ☐ Yes ☐ No *If no, indicate brand/size of supplies:*____________________

Can the member use the bathroom alone? ☐ Yes ☐ No If no, explain assistance: ____________________

Does the member wear pull ups/diapers at night? ☐ Yes ☐ No *If yes, indicate brand/size of supplies:* ____________________

Will member tell someone if bathroom is needed? ☐ Yes ☐ No **Is the member on a toileting schedule?** ☐ Yes ☐ No

SLEEPING:

Does the member usually sleep through the night? ☐ Yes ☐ No *Approximate time member goes to bed:* ____________________

List any issues related to sleeping, special equipment needed, etc.:

____

WALKING:

Is applicant ambulatory? ☐ Yes ☐ No

If no, does the applicant use: ☐ Walker ☐ Crutches ☐ Wheelchair ☐ Modified shoes

Does equipment meet current needs? ☐ Yes ☐ No *If no, explain:* ____________________

LANGUAGE:

Is the member verbal? ☐ Yes ☐ No *If no, complete the questions below:*

How does the member make his/her needs known? ____________________

Does the member understand one- or two-word commands? ☐ Yes ☐ No

Does the member follow one/two-step commands? ☐ Yes ☐ No

Explain any communication needs (devices, etc.): ____________________

BEHAVIOR:

Does the member have a history of: ☐ Property destruction ☐ Physical aggression ☐ Verbal aggression

What does this usually look like? ____________________

If known, what are triggers to behavior(s)? ____________________

Does member usually hurt him/herself or others? ☐ Yes ☐ No

Describe any other inappropriate behaviors the member may have:

____

19. STRENGTHS/ABILITIES/PREFERENCES

Personal strengths, assets and capabilities:

____

Natural supports:

____

Religious, spiritual and/or cultural considerations:

____

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

____

20. TREATMENT GOALS

☐ **Please attach a copy of the member's Person-Centered Plan/Individual Support Plan (if applicable), including Identification of the service(s) being requested.**

☐ **If the member is currently admitted to an inpatient facility, attach a copy of his or her Inpatient Treatment Plan, including identification of the service(s) being requested.**

21. ADDITIONAL INFORMATION (REQUIRED)

Provide information related to the member's current status, symptoms, notable improvements/changes, etc. Also include any additional comments that may support this application.

22. REFERRAL CHECKLIST

In the second column, indicate each item attached to this application. Please comment on reasons items are missing or items that will be sent at later time.

Item	Status
CCA/psychiatric assessment/evaluations/diagnostic assessment	☐ Attached Comment: ____________________
Person-Centered Plan/ISP/Inpatient Treatment Plan	☐ Attached Comment: ____________________
Psychological testing	☐ Attached Comment: ____________________
Physical assessment/medical information	☐ Attached Comment: ____________________
Sexually Aggressive Youth Evaluation/Sex Offender-Specific Evaluation	☐ Attached Comment: ____________________
DSS records (if applicable)	☐ Attached Comment: ____________________
DJJ records (if applicable)	☐ Attached Comment: ____________________
Court orders (if applicable)	☐ Attached Comment: ____________________
Signed Authorization and Consent for Release of Information	☐ Attached Comment: ____________________
Other: ____________________	☐ Attached Comment: ____________________

SIGNATURES

Treatment service coordinator printed name	**Date**
Treatment service coordinator signature	**Date**
Legally responsible person printed name	**Date**
Legally responsible person signature	**Date**
Member's signature	**Date**