



UNIVERSAL APPLICATION

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

CHILDREN AND FAMILY SERVICES

SFN 824 (7-2022)

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 Doe		Name (First, Middle Initial) Jane		Date of Birth 11/29/2009
Gender <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female <input type="checkbox"/> Other (specify):			FC Case Number (FRAME) FC9090909	
Court Case File Number(s) 00-2019-JV-0000				
Race and Ethnicity (check one) <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> White <input checked="" 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 English		Age 13	Height 5'	Weight 115
Eligibility: Check all that apply <input checked="" 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 checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		ND Medicaid Number 123456		
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 1234 Residential Street		City City	State ND	ZIP Code 58300
Date Entered into Foster Care 09/23/2020	Age at Entry Into Foster Care 11	Financially Responsible County/Zone Mountain Lakes Human Service Zone-Ramsey		
Current Residence Address 123 Residential Street		City City	State ND	ZIP Code 58000
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 checked="" type="checkbox"/> Other (specify): <u>Detention</u> <input type="checkbox"/> Family Foster Care - Therapeutic/Treatment (TFC)				

INFORMATION SOURCES					
Case Manager Name Sally Guardian		Legal Custodian Agency Name Mountain Lake Human Service Zone		Case Manager Telephone Number (701) 555-1234	
Case Manager Email Address guardian@email.com				Case Manager Fax Number (701) 555-1244	
Name(s) of Parent(s) (if not in public custody)		Legal Custodian Type <input type="checkbox"/> DJS <input checked="" type="checkbox"/> County <input type="checkbox"/> Tribe <input type="checkbox"/> Parent		Parent(s) Telephone Number	
Address 1234 County Street		City City		State ND	ZIP Code 58000

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)
Mary Jones	Biological Grandmother	(701) 111-1111	5	C,V; previously resided with
Lisa Lee	Therapist	(701) 511-1111	4	C,V

Involvement - If rated 1,2,3, or 4 above, describe each primary support's involvement in further detail, giving specific examples. Jane previously resided with Grandmother, Mary Jones, (last 10 years) who is the primary support. Mary will act as the primary support if/when Jane is approved for QRTP. Child was placed at a shelter due to ongoing violent gang behavior in guardian's home (e.g. Child has struck the other children in the home, attempted to strike grandmother); She is worried about the safety of herself and the other children. Jane meets with therapist on a weekly basis for the past 2 years to discuss previous trauma, depression, and anxiety.

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 Home on the Range	Facility Dakota Boys and Girls Ranch	Facility
QRTP Admission Date	Date if Already Admitted as an Emergency Placement Entered into QRTP prior to assessment, enter date here	
Proposed Admission Date 12/30/2022	Anticipated Discharge Date 03/30/2023	

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 123 Street	City City	State ND	ZIP Code 80000
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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
District Juvenile Court

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)
Detention	Grand Forks	11/20/22-present	Legal charges, substance use	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Shelter		10/20/22-11/20/22	aggressive behaviors	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Runaway, substance use
Relative Home/ Guardianship	Maternal Grandmother (Mary Jones)	2012-10/20/22	Neglect by Mother	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Physical aggression
Biological Parental Home	Biological Mother (Katie Doe)	2009-2012		<input type="checkbox"/> Yes <input type="checkbox"/> No	Mother using substances, neglect

If the child is placed in a treatment setting, explain in detail the child's discharge plan:
(If the child is APPROVED and placed in a QRTP, what is the anticipated discharge plan once ready for discharge?)
Current plan entails transitioning into grandparents' home. Child will also continue therapeutic interventions such as weekly individual therapy and family therapy to support long term goal to return to her mother.

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:

Child was placed in a shelter on 10/20/2022 due to being a risk to herself and the other children in her grandmother's home (e.g., hitting other children and grandmother frequently with the last incident being on 10/19/22). Child also began experiencing suicidal ideation with a plan and intent, disclosed to current therapist on 11/15/2022. She was then detained for use of marijuana and methamphetamine on 11/20/2022 with pending legal charges.

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

On 10/1/2022, the child hit other children and grandmother. On 10/15/2022, the child held a knife to her own neck and threatened to harm herself. On 10/19/2022, she punched her grandmother in the face causing a black eye. She ran away from her shelter placement on 11/20/22 and was detained after she was found for illegal substances and running away.

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

The family and youth would require family therapy and individual therapy focused on self-regulation, anger management, suicide prevention, and substance use treatment.

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

The following treatment services have been provided and didn't provide adequate treatment or support for the child given continued behaviors (e.g., physical aggression, running away, suicidal ideation, illegal substance abuse): in-home family therapy, individual therapy, medication management, psychological evaluation, partial hospitalization, inpatient hospitalization, juvenile probation including detention, informal placement with relatives, IEP, shelter placement

If the child was placed in a QRTP within the last six months please describe in detail what community services and supports have been provided to the child and family and what about these services has not met need:

The child has not been in a QRTP within the last 6 months.

If the child was in a QRTP within the past 6 months, an example may be:

In-home family therapy, individual therapy, medication management, psychological evaluation, partial hospitalization, inpatient hospitalization, juvenile probation including detention, informal placement with relatives, IEP, and shelter placement have all been provided. The child's behaviors have continued to escalate despite supports and aftercare services placing herself and others at risk.

CHILD AND FAMILY STRENGTHS AND RESILIENCY FACTORS

<input checked="" type="checkbox"/> Asks for support when needed	<input type="checkbox"/> Genuine interest in school	<input checked="" 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 checked="" type="checkbox"/> Abuse history (emotional, physical, sexual) victim	<input type="checkbox"/> Divorce
<input type="checkbox"/> Acculturation difficulty (e.g. refugee status)	<input checked="" type="checkbox"/> Domestic Violence
<input type="checkbox"/> Adopted	<input type="checkbox"/> Employment instability
<input type="checkbox"/> Homeless	<input checked="" type="checkbox"/> Family discord
<input type="checkbox"/> Unsafe Neighborhood	<input checked="" type="checkbox"/> Poverty/inadequate finances
<input checked="" type="checkbox"/> Substance use by parents or primary support	<input type="checkbox"/> Unstable Illness
<input checked="" 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 checked="" type="checkbox"/> Removal from home
<input checked="" type="checkbox"/> Death of a family member or primary support (describe): grandfather 2021	<input checked="" 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 checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Property destruction	<input type="checkbox"/>	<input checked="" 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 checked="" type="checkbox"/>	<input type="checkbox"/>	Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance use	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
School Refusal	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Harm to animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other: _____			
School Misbehavior	<input checked="" 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 checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal threats	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other: _____			
Impulsivity	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Diagnosis: Major Depressive Dx			
Self care/Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Delinquent behavior	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Diagnosis: Oppositional Defiant Dx			
Depression	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peer relationship issues	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Diagnosis: Generalized Anxiety Dx			

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.
- ☐ If the child was placed in a QRTP in the past 6 months attach all aftercare documentation.

REFERRAL INFORMATION

Who completed the form? <input checked="" type="checkbox"/> Case Manager <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____		
Name of Referrer Sally Guardian	Referral Date 01/01/2023	
Email Address guardian@email.com	Telephone Number (701) 555-1234	Fax Number (701) 555-1244