



*Creating solutions, One person at a time*

## Instructions for Completing The Universal Application

The Universal Application offers a comprehensive clinical review of a consumer's needs without having to complete several agency specific applications. A PDF and Word version of the application is posted on the PBH website ([www.pbhcare.org](http://www.pbhcare.org)) on the PBH Provider webpage for your convenience. You will also be able to find a copy of the application at the PBH UM Homepage in the future.

Instructions for completing the Universal Application are listed below.

1. The Universal Application should be completed in full. Please answer each question do not leave questions or sections blank. If not applicable please write N/A. Applications will be returned to referring party if deemed incomplete.
2. Please do not write "see attached" in sections requiring specific detail. If you have a document that provides greater detail then can be written, please reference the document name, date and page number at the end of your explanation. Ex. (Psychological Evaluation, 2-2-09, Page 3)
3. For PRTF referrals please forward a copy of the Universal Application to PBH UM/Attn: PRTF Care Manager (Fax: 704-743-2130).
4. Please have Legal Guardian sign Universal Application.
5. If you have questions about completing the Universal Application please contact PBH UM at 704-743-2100.



Consumer Name  
MID#

## UNIVERSAL RESIDENTIAL SERVICES APPLICATION

Date of Application \_\_\_\_\_ Date Service Needed: \_\_\_\_\_

Type of Referral:

- Planned and Emergency Respite
- Residential Level 2
- Residential Level 3
- Residential Level 4 Secure
- PRTF

### 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: \_\_\_\_\_

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?

**5. MEDICAL INFORMATION**

Allergies: \_\_\_\_\_

Special Dietary Needs: \_\_\_\_\_

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

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Lice                             | <input type="checkbox"/> Bulimia            | <input type="checkbox"/> Eczema                 |
| <input type="checkbox"/> Anemia                           | <input type="checkbox"/> Anorexia           | <input type="checkbox"/> Asthma                 |
| <input type="checkbox"/> Drug/Alcohol Abuse               | <input type="checkbox"/> Measles            | <input type="checkbox"/> Hay Fever              |
| <input type="checkbox"/> HIV/AIDS                         | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Convulsions            |
| <input type="checkbox"/> Sexually Transmitted Disease     | <input type="checkbox"/> Chicken Pox        | <input type="checkbox"/> Sinus Problems         |
| <input type="checkbox"/> Ringworm                         | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Diabetes               |
| <input type="checkbox"/> Tuberculosis                     | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Hepatitis              |
| <input type="checkbox"/> Chronic Urinary / Bowel Problems | <input type="checkbox"/> Rubella            | <input type="checkbox"/> Traumatic Brain Injury |
| Other: _____  | Other: _____                                | Other: _____                                    |

Name and Address of Pediatrician: \_\_\_\_\_

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? \_\_\_\_\_

**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

**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.

<input type="checkbox"/> Abandonment Issues	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Arson
<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> Antisocial Behavior	<input type="checkbox"/> Stool/Feces smearing
<input type="checkbox"/> Assaultive (Physical)	<input type="checkbox"/> Assaultive (Sexual)	<input type="checkbox"/> Assaultive (Verbal)
<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Depression
<input type="checkbox"/> Property Destroying	<input type="checkbox"/> Fire Setter	<input type="checkbox"/> Developmental Disability
<input type="checkbox"/> Homeless	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Impulsive
<input type="checkbox"/> Lying	<input type="checkbox"/> Low Self-Esteem	<input type="checkbox"/> Loss/Grief Difficulties
<input type="checkbox"/> Physical Impairment	<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Parent Neglect Issues
<input type="checkbox"/> Perception of Reality	<input type="checkbox"/> Phobic Behavior	<input type="checkbox"/> Physical Disability
<input type="checkbox"/> Self Destructive Behavior	<input type="checkbox"/> Sibling Related Difficulty	<input type="checkbox"/> Oppositional
<input type="checkbox"/> Social Immaturity	<input type="checkbox"/> Sexually Inappropriate Behavior	<input type="checkbox"/> Stealing
<input type="checkbox"/> Suicidal	<input type="checkbox"/> Running Away	<input type="checkbox"/> Truancy
<input type="checkbox"/> Unruly/Ungovernable	<input type="checkbox"/> Cruelty to Animals	<input type="checkbox"/> Hygiene/Cleanliness Issues
<input type="checkbox"/> Problems with Sleep	<input type="checkbox"/> Gang Related Activity	<input type="checkbox"/> History w/ Weapons

Other \_\_\_\_\_

**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: \_\_\_\_\_

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.

<input type="checkbox"/> Criminal Activity	<input type="checkbox"/> Child Abuse
<input type="checkbox"/> Inappropriate Sexual Behavior	<input type="checkbox"/> Treatment Disruption
<input type="checkbox"/> Psychiatric Illness	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Suicide	Other: _____

**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? \_\_\_\_\_

**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)

**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**

<b>Self Injury</b>	<p>Check all that apply <input type="checkbox"/> cuts on body <input type="checkbox"/> conceals cutting- indicate area</p> <p><input type="checkbox"/> other forms of self injury (please describe)</p> <p>Has self-injury ever required medical attention? Please explain:</p>																														
<b>Suicidal Characteristics</b>	<p>Check all that apply <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Past Suicide Attempts <input type="checkbox"/> Suicidal Plans</p> <p>Describe:</p> <p>Methods used in previous attempts- please describe:</p> <p>Were attempts planned: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> sometimes <input type="checkbox"/> don't know</p>																														
<b>Homicidal Characteristics</b>	<p>Check all that apply <input type="checkbox"/> homicidal thoughts <input type="checkbox"/> Past Attempts to harm others <input type="checkbox"/> Homicidal Plans</p> <p>Describe:</p> <p>Methods used in previous attempts- please describe:</p> <p>Were attempts planned: <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> sometimes <input type="checkbox"/> don't know</p> <p>Does consumer have access to weapons? Please explain</p>																														
<b>History of AWOL</b>	<p><input type="checkbox"/> Runs away from home</p> <p><input type="checkbox"/> Has run from previous placements</p> <p>In the past year how many times has consumer run? ____</p> <p>Where does he/she go? _____</p> <p>How long is typically AWOL? _____</p>																														
<b>Substance Abuse History</b>	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:25%;">Type of Substance</th> <th style="width:15%;">Frequency</th> <th style="width:15%;">Last Use</th> <th style="width:25%;">Type of Substance</th> <th style="width:15%;">Frequency</th> <th style="width:15%;">Last Use</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Marijuana</td> <td></td> <td></td> <td><input type="checkbox"/> Amphetamines</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Cocaine</td> <td></td> <td></td> <td><input type="checkbox"/> Hallucinogens</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Heroin/Opiates</td> <td></td> <td></td> <td><input type="checkbox"/> Alcohol</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Inhalants</td> <td></td> <td></td> <td><input type="checkbox"/> Other:</td> <td></td> <td></td> </tr> </tbody> </table>	Type of Substance	Frequency	Last Use	Type of Substance	Frequency	Last Use	<input type="checkbox"/> Marijuana			<input type="checkbox"/> Amphetamines			<input type="checkbox"/> Cocaine			<input type="checkbox"/> Hallucinogens			<input type="checkbox"/> Heroin/Opiates			<input type="checkbox"/> Alcohol			<input type="checkbox"/> Inhalants			<input type="checkbox"/> Other:		
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<b>Sexualized Behaviors</b>	<b>Please describe any sexualized behaviors exhibited by consumer (i.e. exposure, sexual acting out, predatory behaviors, prostitution)</b>
<b>Psychotic Behaviors</b>	<b>Please describe any past/present history of psychosis</b>

<b>19. ADDITIONAL COMMENTS</b>
<p><b>Please use this space to include any additional comments that may support this application</b></p>

<b>20. REFERRAL CHECKLIST</b> In 2 <sup>nd</sup> 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.	
<b>Universal Application</b>	
<b>Person Centered Plan / Sign Page</b>	
<b>Discharge Summaries from Hospitalizations/ Previous Treatment</b>	
<b>Consent to exchange information</b>	
<b>School Records/ IEP</b>	
<b>DSS records (if applicable)</b>	
<b>DJJ records (if applicable)</b>	

Consumer Name  
MID#

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

**21. SIGNATURES**

\_\_\_\_\_  
**Legal Guardian** **Date**

\_\_\_\_\_  
**Treatment Service Coordinator Signature** **Date**

\_\_\_\_\_  
**Supervisor Approval** **Date**

\_\_\_\_\_  
**Clinical Approval** **Date**