ACCESS AND UTILIZATION MANAGEMENT
845 CHURCH STREET N.
SUITE 208
CONCORD, NC 28026

To: PBH Children's Mental Health Providers-Community Support, Intensive In Home, MST, Day Treatment, Respite, Residential II-IV and PRTF

From: Chris Jacobson, LCSW PBH Utilization Management Director

Date: April 27, 2009

RE: Residential Services Universal Application
PBH ACCESS Communication Bulletin FY-0309-UM-01

Effective May 1, 2009 PBH will require the use of the Universal Application for submission to Residential Level II-IV, PRTFs and Respite providers. The Universal Application offers a comprehensive clinical review of a consumer's needs without having to complete several different agency specific applications. With the institution of this process, it is PBH's expectation that the timeframes for referral to and review by Residential, PRTF and Respite providers will be significantly reduced.

A copy of the application will be posted on the PBH website at the UM home page for your convenience. If you have questions or comments please contact Dr. Carroll Lytch at carrolll@pamh.com or call 704-743-2100.

cc. David Jones, MA, LPA PBH Clinical Operations Director
Kristin Baker, MD PBH Clinical Director

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**

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: ____

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

____

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:______________________________

____

CONSUMER'S PRIMARY REFERRAL SOURCE INFORMATION

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

Other: ____

Provider Agency: _ ______________________________ Phone #:__________________________________

Agency Contact Person:_____________________________ Phone #__________________________________

Address: ____

Emergency Contact Person: ____

Telephone: ______________________ **Pager/Cell:** ____________ **Fax:** ______________

Address: ____

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

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** **Other:**____________________________

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? ____

PRESENTING PROBLEMS / REASON FOR REFERRAL

PREVIOUS TREATMENT INTERVENTIONS

Outpatient Intervention	Date	Effectiveness

PLACEMENT HISTORY

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

CURRENT EMOTIONAL / BEHAVIORAL PROBLEMS

Please describe behavior and include the date of last incident.

☐ **Abandonment Issues**	☐ **Anxiety**	☐ **Arson**
☐ **Alcohol/Drug Abuse**	☐ **Antisocial Behavior**	☐ **Difficulty With**
☐ **Assaultive (Physical)**	☐ **Assaultive (Sexual)**	☐ **Assaultive (Verbal)**
☐ **Bedwetting**	☐ **Eating Disorder**	☐ **Depression**
☐ **Destroying Property**	☐ **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**	

Other: ____

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

Are siblings in out-of-home placements? _____________

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

☐ **Incarcerated** ☐ **Group Home**

Other: ____

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:**

If other pertinent family history please document separately and attach.

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?

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: ____

AGENCY INVOLVEMENT

Indicate all agencies currently involved:

☐ **DSS** ☐ **Mental Health Provider** ____

☐ **DJJ** ☐ **Voc Rehab** **Other:** ____

COURT HISTORY

Does Consumer have a criminal record? ☐ **Yes** ☐ **No**

Offenses	Conviction Dates

Pending Charges: _______________________________________

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

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

TREATMENT GOALS

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

History of Self Injury and Risk Behaviors

	☐ **cuts on body** ☐ **conceals cutting- indicate area** ☐ **other forms of self injury (please describe)**

Self Injury	**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	(see table below)
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**

Substance Abuse History

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

SIGNATURES

Treatment Service Coordinator Signature **Date**

Supervisor Approval **Date**

Clinical Approval **Date**

ADDITIONAL COMMENTS

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

REFFERRAL 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)	
Psychological Testing	
Sexually Aggressive Youth Evaluation	
Immunization Records	
Birth Certificate	
Copy of Medicaid/ Insurance Cards	
Psychiatric evaluations	
Diagnostic Assessment (or any other assessment completed)	