UNIVERSAL APPLICATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CHILDREN AND FAMILY SERVICES
SFN 824 (3-2025)

Clear Fields

Directions: This form is completed by the custodian (public agency worker if in public custody or parent or legal guardian if in private custody) detailing current and immediate need for out of home treatment. In addition to this form; the custodian, parent, or legal guardian must attach additional information to support the need for treatment. If referred by a **parent or legal guardian**, the completed form must first be submitted to the HHS screener.

*In compliance with the Federal Privacy Act of 1974, the disclosure of the social security number on this form is voluntary. They are not disclosed to the public. The numbers are used to maintain accurate files. Therefore, while voluntary disclosure is requested, failure to do so will not invalidate this application.

In order to accept the application, the referral must attach details up to the past 90 days specific to:

- ☐ Recent discharge information (if previously placed in a facility/treatment setting, including inpatient psychiatric hospitalization);
- ☐ Assessment, testing, IEP, medication list, or specialist evaluations;
- ☐ Progress notes specific to therapeutic intervention (individual, family therapy of psychiatrist reports);
- ☐ If the child was placed in a QRTP in the past 6 months attach all aftercare documentation;
- ☐ Narrative: May be submitted to support attached clinical documentation, but may not be used in place of clinical documentation.

CHILD DEMOGRAPHICS AND INFORMATION SOURCES

Last Name	Name (First, Middle Initial)	Date of Birth

Current Residence Address	City	State	ZIP Code

Child's Current Living Arrangement (or type - e.g., home, foster home, etc.)

- ☐ Family Setting (parents)
- ☐ Family Setting (relatives) (specify): _____
- ☐ Family Foster Care (licensed)
- ☐ Treatment Foster Care (TFC)
- ☐ Qualified Residential Treatment Program (QRTP)
- ☐ Psychiatric Residential Treatment Facility (PRTF)
- ☐ Other (specify): _____

Gender	Age	Height	Weight
☐ Male ☐ Female ☐ Other (specify):			

Race and Ethnicity (check all that apply)

- ☐ Asian
- ☐ Black/African American
- ☐ Other (specify):
- ☐ Hispanic or Latino
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ American Indian/Alaska Native (specify Tribal affiliation):

If in Public Custody, Court Case File Number(s)	If in Public Custody, Date Entered into Foster Care

If in Public Custody, Foster Care Payment Source (check one)

☐ Title IV-E ☐ Regular Match ☐ Emergency Assistance ☐ Tribal IV-E ☐ Tribal 638 ☐ URM ☐ Out of State

Other Payment Source

☐ SSI ☐ SSDI ☐ N/A ☐ Other (specify):

ND Medicaid Eligible	ND Medicaid Number	Social Security Number (If not on ND Medicaid)
☐ Yes ☐ No ☐ Unknown		

Third Party Insurance	Name of Insurance Policy Holder
☐ None ☐ Yes (provide requested details)	

Insurance Policy Number	Name of Insurance Company	Insurance Company Telephone Number

INFORMATION SOURCES

Public Custody (Human Service Zone, DJS and Tribal Nations)	**Private Custody (Parent/Legal Guardian)**
Case Worker **AND** Agency Name	Parent /Legal Guardian Name
Telephone Number	Telephone Number
Email Address	Email Address

Information Sources: Individuals to be interviewed as part of the assessment including members of the Child and Family Team (CFT), treatment providers, parent/legal guardian involved in the child's case. Telephone number and email addresses are required. If one is not available indicate why in the boxes below:

Name of Primary Support or Child & Family Team Member	**Relationship to Child** (mother, father, sibling, grandparent, guardian ad litem, foster care provider, teacher, treatment provider, therapist, case worker, school personnel, etc.)	**Telephone Number**	**Email Address**

Involvement: Describe each primary support's involvement in the child's treatment, giving specific examples.

SERVICES SOUGHT/REFERRAL TYPE

Services Sought/Referral Type Applying for (check all that apply)

- ☐ Family Foster -TFC
- ☐ Psychiatric Residential Treatment Facility (PRTF)
- ☐ Qualified Residential Treatment Program (QRTP)

If working with a QRTP or PRTF, what is the facility name?

Was the child placed as an emergency placement at TFC, QRTP, or PRTF?

☐ Yes ☐ No - If no, is there a proposed admission date? ☐ No ☐ Yes - If yes, what is the date?

If the child was placed as an emergent placement complete the following:

Facility	
Admission Date	Anticipated Discharge Date

Will the child's 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	City	State	ZIP Code

For children in public custody, the Assessment Outcomes Report will be sent to the custodial case worker and to the court. 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

PLACEMENT HISTORY

Describe where the child has resided for the past **6 months** (including the child's parental home, if applicable).
Begin with where the child is currently residing.

Setting (e.g. TFC, QRTP, PRTF, hospitalization, foster, parental home, etc.)	**Provider** (if applicable)	**Start Date**	**End Date**	**Reason for Placement**	**Describe why the placement ended** (provide details)

If the child is currently placed out of the home or approved to be placed in a treatment setting, explain in detail what the discharge plan is including **where the child will reside** when treatment is no longer required.

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:

What are the **current** (last 90 days) behaviors or safety risks that require treatment placement for the child?

What current or recent services and supports have been attempted and implemented to help maintain the child in a family setting? Describe in detail why the services have been determined insufficient or ineffective.

If the child was placed in a Treatment Setting/Facility within the last six months please describe the aftercare efforts made by the agency and detail what community services and supports have been provided to the child and family and what about these services has not met need:

CHILD AND FAMILY STRENGTHS AND RESILIENCY FACTORS

- ☐ Asks for support when needed
- ☐ Confident
- ☐ Cultural identity
- ☐ Empathetic
- ☐ Follows rules
- ☐ Genuine interest in school
- ☐ Hobbies
- ☐ Optimism
- ☐ School work/chores independently
- ☐ Social
- ☐ Resilient
- ☐ Spirituality
- ☐ Talents/interests
- ☐ Vocational/work ethic
- ☐ Other (describe): _____

Family Strengths

☐ Cultural identity ☐ Interpersonal ☐ Optimism ☐ Spirituality ☐ Talents/interests ☐ Vocational/work ethic ☐ Other

Describe in detail the child and family strengths identified above.

CHILD'S CURRENT AND CONSISTENT BEHAVIOR/SYMPTOMS

This is specific to the past 90 days only. The custodian, parent or legal guardian must provide the recent progress notes and incident reports that support boxes checked below.
D=Daily; W=Weekly; M=Monthly

	D	W	M
Anxiety/Excessive worry	☐	☐	☐
Danger/Violence to others	☐	☐	☐
Threatening behaviors or actions	☐	☐	☐
School refusal	☐	☐	☐
School misbehavior	☐	☐	☐
Intentional misbehavior	☐	☐	☐
Impulsivity	☐	☐	☐
Self care/Hygiene	☐	☐	☐
Depression	☐	☐	☐
Property destruction	☐	☐	☐
Psychosis	☐	☐	☐

	D	W	M
Physical aggression	☐	☐	☐
Fire setting	☐	☐	☐
Harm to animals	☐	☐	☐
Harm to self	☐	☐	☐
Suicidal thoughts or statements	☐	☐	☐
Suicide attempts	☐	☐	☐
Problems with authority/ Following rules	☐	☐	☐
Peer relationship issues	☐	☐	☐
Runaway	☐	☐	☐

	D	W	M
Panic attacks	☐	☐	☐
Sexually abusive behaviors	☐	☐	☐
Sexual exploitation	☐	☐	☐
Substance use	☐	☐	☐

- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

If needed, provide further detail regarding the child's physical, mental, intellectual or developmental diagnoses. In addition, list medications and/or assessment details not attached.

By typing my name below, I am signing this document electronically. I agree that my electronic signature is the legal equivalent of my manual/handwritten signature. I agree that the electronic signature appearing on this document has the same validity and enforceability as a handwritten signature. Parent or Legal Guardian signature is required for those who are not in public custody. By signing this form I am authorizing those listed on this form to participate in the assessment process.

REFERRAL INFORMATION

Who completed the form?

☐ HSZ ☐ DJS ☐ Tribal Nation ☐ Parent/Legal Guardian ☐ Other: _____

Name of Referrer	Signature of Parent/Legal Guardian (if applicable)	Referral Date
Email Address		Telephone Number

TREATMENT AGENCY ONLY:

☐ If the child was placed as an emergency placement, the treatment agency must submit the SFN 831 Children's Treatment Services Level of Care Determination Attestation and initial supporting documentation to Maximus within 48 hours of placement.