BlueCross BlueShield of North Carolina | Healthy Blue Care Together

Blue Cross® and Blue Shield® of North Carolina (Blue Cross NC) | Healthy Blue® Care Together | Medicaid

Residential Placement Universal Referral Form

Instructions for Completing the Application

1. **Complete every section**: Ensure the application form is filled out entirely. Answer every question as accurately as possible. If a question does not apply or information is not available, enter **N/A** or **information not available**. Please note that incomplete applications may be returned to the individual who initiated the referral.
2. **Provide detailed information**: Avoid using *see attached* in areas that require specific details. If further information is available in another document, reference the document by its name, date, and page number following your explanation — for example, *Physical Assessment, 07.01.15, page 3*. Make sure to include any referenced documents when submitting your application.
3. **Obtain necessary permissions**: The individual filling out this form is responsible for acquiring any required permissions or authorizations to disclose protected health information.
4. **Signature requirement**: The application must be signed by the individual legally responsible for the member, as defined by N.C.G.S. § 122C-3(20). This may include a parent, guardian, someone acting in loco parentis, or a legal custodian with the authority to consent to medical or psychiatric care.

Disclaimer: This form is designed to streamline the discharge planning process and prevent redundant applications for various agencies. However, using this form does not guarantee that the plan will authorize residential or other treatments, nor does it guarantee admission by any service provider. The facility discharging the patient retains responsibility for ensuring an appropriate discharge process.

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Date referral form completed:		**Date service needed:**	

Type of Referral Service/Level of Care Sought	
☐ Residential Level I — family type	☐ Individual Supports — mental health (Medicaid)
☐ Residential Level II — family type	☐ Crisis Stabilization and/or emergency (short-term placement)
☐ Residential Level II — program type	☐ Intensive alternative family treatment (IAFT)
☐ Residential Level III — group home	☐ Rapid response placement (RRP)
☐ Residential Level IV — secure	☐ Long-term community supports — intellectual/developmental disability residential services (Medicaid)
☐ Psychiatric residential treatment facility (PRTF)	☐ Intermediate care facility for individuals with intellectual disabilities (ICF/IDD)

Member name:	
Social Security number:	
DOB:	
Medicaid number:	
Address:	
City:	
County:	
State:	
ZIP code:	

Referral Source Information		
Referring agency:		
☐ Hospital	☐ Clinical home provider	☐ Department of Juvenile Justice and Delinquency Prevention (DJJ)
☐ Healthy Blue Care Together] placement specialist	☐ Department of Social Services (DSS), county:	☐ Other:

Name of referring agency:	
Contact person:	
Phone number:	
Email:	
Alternate contact number	
Fax number:	
Reason for referral:	

Member Demographic Information			
Member name:			
Preferred name:			
Date of birth:		Age:	
Race:			
Place of birth:			
Primary language:			
English speaker:		☐ Yes ☐ No	
County from which Medicaid originates:			
Open to placement in specific counties?		☐ Any ☐ Specific counties (list below):	
Current living arrangement:			
Special considerations (Examples include safety concerns, no pets, can't share a bedroom, no other children in the home, gender-specific parent, single-parent home)			
Describe the skill set that potential resource parents, caretakers, or staff will need to serve this child/ youth (this helps to identify the best possible placement):			

Legally Responsible Person Information	
Legally responsible person:	☐ County, DSS ☐ Other
Name of CCW:	
Relationship to member:	
County of legal custody:	
Permanency plan:	
Termination of parental rights?	☐ Yes ☐ No
If yes, date and by whom?	
Home phone:	
Work phone:	
Mobile phone:	
Mailing address:	
Email:	

Family Information	
Are any natural supports involved (for example, bio parents, grandparents, aunts, or uncles)?	☐ Yes ☐ No
Are there religious, spiritual, or cultural considerations?	☐ Yes ☐ No
Are there existing visitations?	☐ Yes ☐ No

Are the visits supervised?	☐ Yes ☐ No
If yes, by whom?	
If there are existing visitations, with whom, where, and how often? (Visits can include birth parents, grandparents, siblings, former foster parents, and other important connections for the child/youth.)	
Does the member have siblings?	☐ Yes ☐ No
If yes, list their names:	
Are you seeking placement of the siblings together?	☐ Yes ☐ No
If yes, which siblings?	

Clinical/Diagnostic Information			
DSM-5 diagnostic information			
Code:		Diagnosis	
Primary diagnosis:		Secondary diagnosis:	
IQ:	☐ High-functioning ☐ Average-functioning ☐ Low-functioning		

Medication Information		
See attached medication list. (If the list is attached, it is not necessary to complete this section.)		
Medication	**Dose/Route**	**Is the member compliant?**
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Treatment and Placement History	
Number of out-of-home placements:	
Has the member been hospitalized?	☐ Yes ☐ No
If yes, how many times in the past year?	
Has the member been in residential placement in the past year?	☐ Yes ☐ No
If yes, where?	

Has the member had a psychosexual evaluation?	☐ Yes ☐ No	
If yes, date of most recent:		
Has the member had a trauma evaluation?	☐ Yes ☐ No	
If yes, date of most recent:		
Has the member received trauma treatment?	☐ Yes ☐ No	
If yes, describe:		
Current Symptoms/Observations		
Check all that apply. Please only include behaviors that have occurred over the last 12 months. Include specific details and/or the date of the last incident, if known and applicable		
☐ Abandonment issues	☐ Anxiety	☐ Difficulties at school
☐ Stool/feces smearing	☐ Sexually inappropriate behavior	☐ Fire-starting/arson
☐ Bedwetting	☐ Eating disorder behavior	☐ Problems with sleep
☐ 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
☐ Gang-related activity	☐ History with weapons	
☐ Abuse/trauma history:	☐ Victim of neglect	☐ Victim of physical abuse
	☐ Victim of sexual abuse	☐ Witness to any of the above
	Other trauma (such as natural disaster, fire, car crash, violence, systemic racism)	
If any of the above options are checked, provide a brief description:		

Risk Assessment		
☐ **Self-injurious behavior (Select 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	
If yes, explain:		
☐ **Suicidal characteristics (Select all that apply)**		
☐ Suicidal thoughts		
☐ Past suicide attempts		
☐ Suicidal plans		
If checked above, describe:		
Were attempts planned?	☐ Yes ☐ No ☐ Sometimes ☐ Unknown	
☐ **Homicidal characteristics (Select all that apply)**		
☐ Homicidal thoughts		
☐ Past attempts to harm others		
☐ Homicidal plans		
Describe methods used in previous attempts:		
Were attempts planned?	☐ Yes ☐ No ☐ Sometimes ☐ Unknown	
Does the member have access to weapons?	☐ Yes ☐ No	
Explain:		
☐ **History of elopement (Select 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 the member go?		
How long are they typically away from home/placement?		
☐ **Sexualized behaviors (Select all that apply)**		
☐ Sexual acting out	☐ Deviant sexual behavior	
☐ Sexual exploitation	☐ Other (describe)	
Psychotic symptoms (Select all that apply)		

☐ Auditory hallucinations	☐ Visual hallucinations
☐ Other (describe):	

Substance Use Information			
Type of substance	Route	Frequency	Last use
☐ Alcohol			
☐ Amphetamines			
☐ Benzodiazepines/hypnotics			
☐ Nicotine/e-cigs/JUULs			
☐ Marijuana			
☐ Inhalants			
☐ Heroin/opiates			
☐ Hallucinogens			
☐ Cocaine			
☐ Other (specify):			

Medical Information			
Allergies:			
Drug allergies:			
Special dietary needs:			
Is the youth up to date on CDC-recommended vaccines for their age group? ☐ Yes ☐ No			
Has the youth ever declined or delayed a CDC-recommended vaccine? ☐ Yes ☐ No			
Has the youth received vaccination(s) for COVID-19? ☐ Yes ☐ No			
If yes, include the total number of doses received and the dates for the vaccination dose(s), if known:			
Height of child:		Weight of child:	
Hair color:		Eye color:	
Identifying marks:			

Past and Present Medical Conditions	
☐ Acquired brain injury	☐ Diabetes/insulin-dependent
☐ Asthma	☐ Diabetes/non-insulin dependent
☐ Autism	☐ Migraines/headaches
☐ Blind	☐ Sickle cell anemia
☐ Cancer	☐ Down syndrome
☐ Cerebral palsy	☐ Epilepsy
☐ Chronic urinary/bowel problems	☐ Hearing impaired
☐ Chronic constipation	☐ Hepatitis
☐ Chronic otitis media	☐ Seizures/epilepsy
☐ Daily respiratory treatment	☐ Other (specify):

Are there additional medical concerns or needs?	

Educational/School Information			
Last school enrolled:			
Highest grade level completed:			
Is it important that the member remain in their current school?	☐ Yes ☐ No		
Can the member attend a full day of school?	☐ Yes ☐ No		
Does the member have a current IEP?	☐ Yes ☐ No	Date:	
Grade(s) repeated:			
Special classes:			
☐ EC	☐ LD		
☐ Resource	☐ BED		
☐ Homebound	☐ Day treatment		
☐ Other:			
History of suspensions or expulsions?	☐ Yes ☐ No		
If yes, please explain:			

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) and counties where the charge occurred:	
Briefly describe prior offenses and conviction dates (if known):	

Daily Living Skills Information (Required only for members with I/DD or co-occurring I/DD and mental health diagnosis)	☐ **N/A Proceed to next section**
Eating	
Specialized diet/diet order?	☐ Yes ☐ No
If yes, explain:	
Does the member eat independently?	☐ Yes ☐ No
Food texture:	
☐ Food eaten at normal consistency	☐ Food consistency altered
☐ Ground	☐ Chopped
☐ Thickener	☐ Puree
Toileting	

☐ Toilets independently	☐ Requires physical assistance/equipment
☐ Scheduled bladder program	☐ Scheduled bowel program
☐ Requires prompts/monitoring	☐ Incontinent/requires disposable briefs
Bathing	
☐ Independent	☐ Requires support to bathe/shower
☐ Independent with devices	
Sleeping	
Does the member usually sleep through the night?	☐ Yes ☐ No
Approximate time member goes to bed:	
List any issues related to sleeping, such as special equipment needed:	
Walking	
Is the member ambulatory?	☐ Yes ☐ No
Does the member use any of the following?	
☐ Walker	☐ Crutches
☐ Wheelchair	☐ Modified shoes
Does equipment meet current needs:	☐ Yes ☐ No
If no, explain:	
Communication	
☐ Verbal	☐ Communicates with device
☐ Communicates with signs	☐ Nonverbal
☐ Communicates with gestures	
Explain any communication needs, such as devices:	
Behavior	
Does the member have a history of any of the following?	
☐ Property destruction	☐ Physical aggression
☐ Verbal aggression	
What does this behavior usually look like?	
If known, what are the triggers for the behavior(s)?	
Does the member usually hurt themselves or others?	☐ Yes ☐ No
Has the member exhibited any behaviors indicating a risk of physical harm to themselves or others in response to triggers? (e.g., throwing objects, hitting, or self-hitting when feeling overwhelmed or threatened)	☐ Yes ☐ No

Describe any additional trauma-related behaviors the member displays on a regular basis (at least once per week)	

Additional Information
Please provide a comprehensive overview of the young person's current living situation, highlighting any challenges, behaviors, and needs they may have. Additionally, share any recent improvements or positive changes, as well as the youth's strengths. Include any other insights that might support a deeper understanding of their experience and this application.

Referral Checklist ***Please attach any of the following that are available:***		
☐ Up-to-date person-centered plan and/or individual support plan	☐ DSS records	
☐ Inpatient treatment plan	☐ DJJ	
☐ Up-to-date Comprehensive Clinical Assessment (CCA)/psychiatric assessment/ evaluations/diagnostic assessments	☐ Court orders	
☐ Psychological testing	☐ Signed Authorization and Consent for Release of Information	
☐ Physical assessments/medical information	☐ Other:	
☐ Sexually aggressive youth evaluation/sex offender-specific evaluation		

Signatures	
Legally responsible person's printed name	Date
Legally responsible person's signature	Date
Member signature	Date