

COMMON APPLICATION For Placement of Children in Residential Care

DESCRIPTION

The Common Application for contracted residential placement of children is the result of a two year cooperative effort between public agency representative and representatives in the private sector.

The application is designed for comprehensiveness and for flexibility, it meets the requirements of all state agencies and local entities associated with a state agency involved in the placement of children. It provides considerable information about a child or adolescent to assist in selection appropriate placements. The completed application can be copied and submitted to all potential providers of service for the child, rather than completing a separate application for each facility considered.

In many instances, agencies that place children in residential settings are currently using forms that contain all the information required in a specific section of the Common Application. In such cases, the existing forms can be inserted into the appropriate section in the Referral/Admissions Packet. In other instances, only partial information is contained in an existing form. When that occurs, the placing agency can insert the existing form and complete the parts of the section that are not covered by the existing form. To facilitate the process of completing the common Application, agencies might want to adapt existing forms so that they conform to those contained in the Common Application.

In summary, the Common Application serves two purposes. It provides information to help determine whether a facility can meet a child's needs, and it provides a single format for use by all state agencies and all private facilities which contact with the state.

The Common Application has three parts:

PART A - Screening Profile

The Screening Profile is a summary of all the information about the child. It highlights the important considerations for placement and tells the care providers where to find more detailed information in part C, the Referral/Admissions Packet.

PART B - Level Of Care

This part of the Common Application contains definitions of the six levels of care that are the basis for making a recommendation for the placement level of care.

PART C - Referral/Admissions Packet

The Referral/Admissions Packet contains detailed information and documentation that elaborates on the contents of the Screening Profile. The information is organized into 12 sections:

1. Social and Developmental Assessment
2. Special Needs, Problems, and Behaviors
3. Juvenile Justice History
4. Placement History
5. Substance Abuse History
6. History of Abuse and Neglect of Referred Child
7. Family History
8. Financial Information
9. Education
10. Physical Health/Disabilities
11. Mental Health
12. Other Attachments
 - A. Birth Attachments
 - B. Legal Records
 - C. Authorization Forms

Attachment Checklist. The form also includes a checklist for attachments, which serves two purposes: First, it gives the referring party a way to monitor which attachments are available, which are not and why, which must be located, and which are unnecessary in a specific case. Second, it tells the receiving party which attachments are included and which are not, thereby eliminating the need to hunt through the entire packet to see what is there.

WHEN TO PREPARE

The caseworker prepares Form 2087 when a decision is made to place a child in residential care.

TRANSMITTAL AND FORM RETENTION

Maintain the original in the child's case record for the life of the record.

COMPLETING THE COMMON APPLICATION

All parts of the common application must be as complete as possible, since it is a continuous record of the child's history, placement, and progress. Sources of information include, but are not limited to, case records, person experience, and interviews with parents, teachers, caregivers, and others familiar with the child.

PART A - SCREENING PROFILE

Although the Screening Profile is the first part of the Common Application, it cannot be completed until most of the information needed to Complete Part C, the Referral/Admissions packet, has been assembled. The information required to complete each section of the Screening Profile is derived from the corresponding section of the Referral/Admissions Packet.

Section 1 - This section asks for a summary of your impressions. Complete it after completing the Social and Developmental Assessment on page 5. The first part asks for your overall impression of the child. The second specifically asks you to summarize the child's strengths.

Section 2 - Check the appropriate boxes, record the number of instances of running away, and list any other problems identified on page 6, "Special Needs, Problems, and Behaviors."

Section 3 - All of the information required to complete this section appears on pages 7 and 8. A referral occurs when a child or the child's parents are brought before juvenile authorities for one or more acts which violate a legal code. There must be a written record of this contact.

Note: If a child appears before juvenile authorities on July 21, 1994, for committing ten burglaries, this counts as one referral, not ten. Similarly, the number of adjudications is the number of separate dates on which the child was adjudicated regardless of the number of referrals or acts involved in the adjudication.

For commitment to the Texas Youth Commission, the number of adjudications for delinquent acts must be at least one, unless the child is classified as a violator of CINS Probation (VCP).

Section 4 - The information for this section appears on page 9 and any continuation pages required to cover the child's complete placement record. Do not include stopover placements, informal placements with relatives, or returns to home.

Section 5 - This section asks about the child's history of substance abuse. Accordingly, if a child has abused a substance at any time, the abuse will be reflected in the severity rating, even if the child does not currently abuse the substance.

The degree of severity is a judgment to be made based on the information on page 10 and any other relevant information available. In general, for substance abuse to be judged severe, it must be considered a primary problem when it occurs. Mild and moderate degrees of substance abuse are secondary problems.

The need for a specialized treatment program should be based upon documentation of habitual substance abuse or records contained in the Referral/Admissions Packet. If the available information indicates that such a program might be required, the caseworker should recommend a complete substance-abuse evaluation.

Section 6 - This section asks whether the child had been abused or neglected. The degree of abuse is a judgment based on the descriptions provided on page 11. If the abuse or neglect was the reason the child was removed from the home, the degree is severe.

Section 7 & 8 - Refer to pages 12-15 to complete these sections. *Note:* Additional judgments or supplemental information may be required to answer some questions (*example:* Can the child return home?).

Section 9 - To complete this section, see section 9 on page 16 and related attachments. *Note:* IQ-test information might be contained in psychological reports rather than in the educational records.

Section 10 - Check whether the child has a diagnosed or suspected health condition or disability. In most cases the physical health problem or disability will be documented in medical records. However, there may be instances in which a physical health problem is suspected but there is no evidence of a problem in the medical records. If there is not a problem or disability, check "No" or "Unknown" and go directly to the next section.

Section 11 - Mental health problems must be documented in the psychological or psychiatric records. If the child has no mental health problems, check "no" or "unknown." Do not enter "see psychological/psychiatric evaluation" in the "Diagnosis" section or in the "Psychotropic Medications" section. The Screening Profile is a summary of the child's history and current status. In many instances, the user will not have the entire common Application and will not be able to refer to other documents. The item "Requires Specialized Treatment" should only be marked "Yes" if there is a psychiatric or psychological report stating that specialized treatment is required.

PART B - LEVEL OF CARE

The six levels of care are described on page 3 of the Common Application. Carefully review the definitions, (Part C, of the Referral/Admissions Packet) and other available information (personal experience, interviews, care records). Follow our agency's procedures for selecting the level of care that best describes the child's behavior, needs, and special problems.

Enter and explain the recommended level of care on page 4. If the billing level of care is different from the recommended level of care, explain why.

PART C - REFERRAL/ADMISSIONS PACKET

The Referral/Admissions Packet is the key to the Common Application. It contains all of the information available regarding the child's history, problems, needs, and goals. For the Common Application to serve its intended purpose, the information available must be organized. This is what the Referral/Admissions Packet does.

It is important that all attachments be placed in the proper section so that care providers can readily locate the specific information they need to make decisions on accepting a child and appropriate program placement. For example, a medical report should be placed immediately following "Section 10 - Physical Health/Disabilities" (page 16), rather than at the back of the Referral/Admissions Packet.

Use the "Attachments Checklist" to record the attachments that are included. When the Common Application is complete, place the "Attachments Checklist" at the front of the Common Application for easy reference, and for updating whenever attachments are added.

1. **Social and Developmental Assessment** - provides a description of the child's general social and developmental history. This section includes a description of the circumstances leading to referral, the immediate and long-range goals of placements, the child's relationship with others, the child's behavior, the child's developmental history, and the child's current level of functioning.
2. **Special Needs, Problems, and Behavior** - provides information relating to history of attempted suicide, assaultive behavior, running away, setting fires, and any other special needs not described in the other sections of the Referral/Admissions Packet.
3. **Juvenile Justice History** - provides a detailed record of the child's referrals and dispositions. It provides a description of the child's history of delinquency and the circumstances and specifics of the most recent adjudicated offense.

If a child already on probation is adjudicated and conditions of probation are modified, enter "AP" as the disposition code. If the referral results in a TYC hearing and the allegation is not proven, enter "RD" as the disposition code.

When determining the total number of referrals, count only one referral per date. When determining the total number of adjudications/certifications, count only one AP, AT, PT, or CA disposition per date.

Do not enter statement such as "see juvenile justice history" in the narrative sections on page 8. These sections are for summarizing and interpreting the youth's delinquency history and pattern. The offenses are already listed on page 7, so there is no need to repeat them.

Be sure the commitment section is complete and accurate. The "time" box is for the length of the determinate sentence, if any. "Time" does not refer to agency-established minimum length of stay.

The "TYC Commitment" section on page 8 refers to the episode that resulted in the current commitment. Put all of the child's court orders involving the juvenile justice system directly under page 8.

4. **Placement History** - provides a complete chronological list of all of the child's placements since the first out-of-home placement. Include both long-term and stopover placements such as emergency shelters, detention, TYC Reception Center, informal placements with relatives, and return(s) home. Detention is listed as a placement only if it occurs between different facilities or living arrangements. Detention is not listed as a placement if the child returns to the same facility or living arrangement from which the child went to detention. *Note:* Stopover placements will not be included in the Screening Profile.

Start with the child's first out-of-home placement and list all placements in order. Use as many pages as necessary. Number the pages in the upper right hand corner by completing "Page ____ of ____," so that the form does not have to be retyped when new placements occur.

5. **Substance Abuse History** - provides information on the child's history of substance use, abuse, manufacture, possession, and/or delivery. It provides similar information for the child's extended family. Any treatment for substance abuse and the outcome is described.
6. **History of Abuse and Neglect** - provides a description of the abuse or neglect experienced by the child. The role of the parent/perpetrator is described, as is the extent of harm to the child.
7. **Family History** - contains information on persons outside the home, characteristics of family members, strengths and weaknesses in the child's relationship with family and significant others, and the overall family situation.
8. **Financial Information** - provides specific information regarding employment for the responsible male and female, Medicaid, and other funds available to the child.
9. **Education** - contains the most recent IEP, ARD committee report, a transcript, and information on the child's adaptive behavior level. It provides a description of any educational problems, needs, or behaviors not included in the educational records.

Place all attachments directly under page 16. If a transcript is not attached, be sure to include the specified information regarding the last school the child attended.

10. **Physical Health/Disabilities** - contains the child's medical and dental records, and provides a description of any physical health problem or disability not contained in those records. Put the specified attachments directly under page 16.
11. **Mental Health** - contains the child's psychological and psychiatric reports, if any, and provides a description of any mental health problems not included in those records. Put the specified attachments directly under page 17.
12. **Other Attachments** - contains the child's birth certificate or other birth verification, legal records not specifically included elsewhere, the authorization forms used by the placing agency, and any other documents deemed relevant and not included in other sections of the Referral/Admissions Packet.