

# Preplacement Screening for Neurodevelopmental and Comorbid Conditions (NACC) Foster Group Care

Youth with Neurodevelopmental and Comorbid Conditions (NACC) have struggled due to the combination of lower cognitive functioning, developmental delays, and serious emotional and behavioral concerns.

Date:

Client Name	Date of Birth	FACS ID	County
Current Living Arrangement			
Referring Worker Name	Referring Worker Contact Information		Legal Status: <input type="checkbox"/> CINA <input type="checkbox"/> Delinquent <input type="checkbox"/> Voluntary

<b>Intellectual Functioning</b>			
Does the youth have an intellectual disability?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If yes, what is the IQ and date of the most recent test?	IQ:		Date:
Has an application for the Intellectual Disability Waiver been completed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
If yes, date of application.			
Does the youth have a diagnosed traumatic brain injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, explain the event in detail.			
Has an application for the Brain Injury Waiver been completed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Date:
If yes, date of application.			

<b>Severe Emotional Disturbance Criteria Checklist</b>	
DSM diagnosis:	
Youth presents with substantial limitations in the following areas:	
Self-care (examples include hygiene, feeding):	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, explain.	
Social and family relationships:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, explain.	
School and work:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, explain.	
Self-direction:	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, explain.	

**History of Behavioral Challenges**

Known history of aggressive or assaultive behaviors?  Yes  No

If yes, provide a brief explanation, including dates and frequency, any injuries, and description of victim's age and other relevant details.

Known history of suicidal ideations, self-injurious behavior, and/or suicide attempts?

Yes  No

If yes, provide a brief explanation, including relevant dates and cite the most recent event.

Known history of sexualized behavior?

Yes  No

If yes, provide a brief explanation, including relevant dates.

**Clinical Services Provided in the Community**

What treatment programs or interventions have been accessed on behalf of the youth? Please include programs that refused admission.

List programs or individual treatment designed to address behavior and emotional needs, as well as, dates of service. Examples could include BHIS, PMIC, waiver, and other group placements.

What past interventions have been the most successful?

What has been the focus of each of these successes?

**Contact Information for Clinician Recommending Residential Treatment for NACC**

**Attach assessment and written recommendation for neurodevelopmental and comorbid condition treatment.**

Name

Date CANS Completed

Credentials

Clinician Name

Address

Phone Number

Email

Other Comments

Case Manager/JCO

Date

**STOP:** SAM or Chief completes final Review of Placement Criteria, suitability, and approval.

**Review of Placement Criteria (Check all that apply.)**

Required for Referral:

- CANS has been completed by a Qualified Individual.
- Qualified Individual recommends NACC residential treatment which requires 1:2 level of staffing.
- Youth is 12+ years old.

Two or more of the following must apply:

- Individual has at least two criteria checked on the SED checklist.
- Individual has an IQ below 75.
- Youth has a diagnosis of Autism Spectrum Disorder.

**Overall Assessment of Suitability for NACC Residential Treatment for Individual**

SAM/Chief (or designee) Decision:

- Not appropriate
- Appropriate

Comments

SAM/Chief (or designee) Signature

Date