IOWA HHS

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			Legal Status: ☐ CINA ☐ Delinquent ☐ Voluntary
Referring Worker Name	Referring Worker Contact Information		

Intellectual Functioning

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

Severe Emotional Disturbance Criteria Checklist

DSM diagnosis:	
Youth presents with substantial limitations in the following areas:	
Self-care (examples include hygiene, feeding): If yes, explain.	☐ Yes ☐ No
Social and family relationships: If yes, explain.	☐ Yes ☐ No

School and work: ☐ Yes ☐ No

If yes, explain.

Self-direction: ☐ Yes ☐ 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 invidual 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 a Licensed Practitioner of the Healing Arts (LPHA) Recommending Residential Treatment for NACC

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

Name	Date TOP Completed by LPHA
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:

- ☐ TOP has been completed by a LPHA.
- ☐ LPHA 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