MAGELLAN BEHAVIORAL HEALTH

Request for Child/Adolescent HCTC Intervention

Form 3.14.6

One of three decisions will be made within seven business days of receipt of a completed packet.
Agencies/providers requesting an HCTC Treatment Intervention **MUST** complete this form
DO NOT revise or amend this form.
Fax the completed packet to Magellan's C/A Residential coordinator Care Manager at 1-866-568-6147

Please Print Clearly

Request Information			
Date Completed:	Date Guardian's Written Request was Received by Behavioral Health Provider:		
Requested by: ☐ CPS ☐ JPO ☐ ADJC ☐ Family Member			
Child/Adolescent Information			
Child/Adolescent Name:		SSN:	
Gender: ☐ Female ☐ Male	DOB:	Age:	
Active T19/21: ☐ Yes ☐ No	AHCCCS Eligibility Verification Date:		
Child/Adolescent's Current Location: ☐ Home ☐ Detention ☐ ADJC Facility ☐ CPS Shelter ☐ CPS Group home ☐ Hospital ☐ CPS Foster Care home ☐ Other Behavioral Health Out of Home Facility (please specify):			
If other than home, date placed:	School:	District:	
Legal Guardian Information			
Name:	Contact Number: ☐ Work: , ext: ☐ Home:		
Mailing Address:			
City:	State:	Zip code:	
Guardian's Primary Language: ☐ English ☐ Other (specify):			
QSP/PNO Information			
QSP/PNO Case Manager Name:	Phone: , ext:	Email:	
QSP/PNO Team Leader:	Phone: , ext:	Email:	
Agency:	Site:	Fax:	
Most Recent CFT Meeting Date:	Next Scheduled CFT Meeting Date:		
Name of Treating Psychiatric Provider:			
Date of Last Visit to the Psychiatric Provider (if a medical professional has not evaluated the child, please schedule an evaluation):			
Date of Scheduled Evaluation:	Evaluator's Name:		

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Section A To be completed by the QSP/PNO Clinician, Case Manager or Facilitator	
Current DSM-IV-TR Diagnoses per Treating Psychiatric Provider (for Axis I and II Diagnoses and Codes)	
Axis I:	
Axis II:	
Axis III:	
Axis IV:	(specify problem area:)
Axis V:	

Medications ☐ Yes ☐ No (If yes, list current medication information)

Medication	Dose	Directions	Compliance
			☐ Full ☐ Partial ☐ Poor
			☐ Full ☐ Partial ☐ Poor
			☐ Full ☐ Partial ☐ Poor
			☐ Full ☐ Partial ☐ Poor

Substance Abuse History ☐ Yes ☐ No (If yes, complete the following)

Substance Class	Age of 1st Use	Date of Last Use	Frequency of Use	Amounts Used
Alcohol				
Amphetamines (Meth)				
Cocaine/Crack				
Hallucinogens				
Inhalants (glue, paint, aerosols)				
Marijuana				
Opiates (prescription narcotics, heroin)				
Other (specify)				

Medical History

Medical Issues:	☐ Yes ☐ No If yes, please specify:
Illnesses:	☐ Yes ☐ No If yes, please specify:
Impairments:	☐ Yes ☐ No If yes, please specify:
Disabilities:	☐ Yes ☐ No If yes, please specify:
Unique Challenges:	☐ Yes ☐ No, If yes, please specify:

Recipient Name:

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Cognitive Level: ☐ Above Average ☐ Average ☐ Below Average ☐ IQ (if available): Full Scale:

Verbal: Performance:

Recent Stressful ☐ Events ☐ Losses ☐ Traumas that Contributed to Current Clinical Needs (specify) ☐ N/A

Services Provided Within the Last 30 Days to Address the Clinical Needs Driving this Referral (Check all that apply)

☐ None

☐ Generalist Direct Support ☐ CD/SA Intensive Outpatient ☐ DBT ☐ Family Therapy ☐ Functional Behavioral Analysis & Plan

☐ Functional Family Therapy (FFT) ☐ Group Therapy ☐ A-CRA ☐ In-Home Therapy ☐ Independent Living Skills Training ☐ Respite

☐ Individual Therapy ☐ Medication Management Visits ☐ Mentor/Behavior Coach ☐ Multisystemic Therapy (MST) ☐ Level I Residential

☐ Parent Partner/Family Support Partner ☐ School-Based Services ☐ Vocational Assessment/Training ☐ Hospital ☐ TGH ☐ L3GH

☐ HCTC ☐ Specialty Therapy: Type: ☐ Other; (describe):

These Services Have Been Provided by the Following Agencies: (list agency names/dates)

Previous Out-of-Home Intervention in Psychiatric Facilities (Attach additional sheets if needed) ☐ N/A

Dates		Length of Stay	Provider/Level of Care	Discharge To
From:	To:			
From:	To:			
From:	To:			
From:	To:			

Evaluation of Current Services to Include Formal and Informal Supports

1. Are the current community supports addressing the identified needs? ☐ Yes ☐ No
2. If no, has the CFT increased intensity/frequency of services or tried different services to address the needs?
   ☐ Yes ☐ No If yes, please describe:
3. Has there been a recent evaluation by a psychiatric provider? ☐ Yes ☐ No
4. If yes, what are the recommendations specific to the intensity of services needed (not a "place" where they can be delivered)?
   ☐ Yes ☐ No If yes, please describe:

Recipient Name:

5. Are there any other community based services or informal supports that can be utilized to address the identified symptoms/behaviors and have they been explored? ☐ Yes ☐ No If yes, please describe:

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SECTION B: Child And Family Team
(Complete this section during a Child/Family Team meeting to support the request for an out-of-home intervention)

If the child moves to an HCTC, the HCTC care giver(s) needs to join the Child and Family Team. The Team must meet regularly and focus on identifying/locating the supports and services needed to enable the child to return to a normative community setting. The goals of the Child and Family Team will become the focus of the treatment plan of the HCTC with the aim of returning the child to their home (biological, kinship, foster/adopt or foster) or non-psychiatric group home at the earliest possible time.

1. State the child's identified targeted treatment goals based on symptoms or behaviors that require an out-of-home treatment intervention. State specific reasons why these targeted treatment goals cannot be addressed with community based supports or services that have been provided or considered in the last 30 days. (Targeted Treatment Goals should reflect behaviors or treatment that cannot be managed utilizing community resources and services, or utilized solely for safety and/or runaway behavior. Targeted Treatment Goals should be limited to one or two behavioral goals)

Child and Family Teams should keep the following in mind when developing Targeted Treatment Goals:

- Be behavioral and clearly reflect the reasons the child/adolescent (C/A) requires a specific level of residential treatment intervention.
- Be measurable. Therefore, the behavior must be observable and must be possible to count the instances of the behavior.
- Be reasonable. The C/A should not be held to a higher standard than a C/A in the community.
- Be behaviors or symptoms that are not able to be addressed with community based services or resources.
- Should be aligned with the behavioral health treatment plan to ensure consistency in goals and approach.

Targeted Treatment Goals

1.

2.

Specific reasons why these targeted treatment goals cannot be addressed with community based supports or services:

Tentative Discharge Planning

Preliminary Discharge Plan - Describe the expected outpatient services and natural supports needed for C/A to succeed in the community, prevent subsequent out-of-home interventions, and to continue addressing current C/A and the family's treatment needs.

a. Residency Plan:

b. Outpatient Services and Natural Supports: (describe type and frequency)

2. What is the expectation of the guardian regarding the child returning home following discharge from HCTC?

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3. If the discharge plan involves reunification with the child's biological, kinship, foster/adoptive, or foster family, what elements are included in the treatment plan that will move the child toward this goal?

4. What is the plan for "parental" involvement regarding therapeutic visitation and provision of assistance for the parent in learning strategies that have proved helpful to the child in the HCTC setting, so that these strategies can carry over following discharge?

5. If Magellan approves the HCTC, what are the CFT's Special Requirements for Home: (check all that apply)

☐ No pets ☐ No other children ☐ No younger children ☐ Male parent only ☐ Female parent only ☐ Couple

☐ Other (specify):

6. What are the Specialized Needs of the Child: ☐ N/A

☐ Substance Abuse ☐ Sexual Misbehavior ☐ Cognitive Disability ☐ Fire Play ☐ Other (specify):

7. Has the CFT reviewed the Out-of-Home FAQ with the guardian? ☐ Yes ☐ No

8. Has the CFT reviewed or involved FSP or Parent supports? ☐ Yes ☐ No

9. Has a referral for High Needs CM been initiated with the PNO if requesting OOH treatment? ☐ Yes ☐ No

Child and Family Team signatures (please indicate your agreement or disagreement with the OOH intervention)

☐ Agree ☐ Disagree	Guardian Signature	Date
☐ Agree ☐ Disagree	Facilitator Signature	Date
☐ Agree ☐ Disagree	Other/Role	Date
☐ Agree ☐ Disagree	Other/Role	Date
☐ Agree ☐ Disagree	Other/Role	Date

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SECTION C: Current Treating Psychiatric Provider (This section is to be completed by the youth's current behavioral health agency treating psychiatrist or nurse practitioner)	
Current medical treating professional's recommendation for level of service needed at this time:	
☐ No recommendation at this time ☐ Remain in/return to the community/home setting with current services ☐ Remain in /return to the community/home setting with additional services. Specify services needed to meet clinical needs:	
☐ HCTC _____ Name (please print) _____ Signature _____ Date	
Phone:	Fax:

SECTION D: Current Juvenile Justice Involvement/Legal History ☐ No ☐ Yes		
If juvenile justice involvement, this section is to be completed by Behavioral Health Staff with the Probation or Parole Officer		
Offense(s)	Reason(s) for Arrest(s)	Dates
Currently on Probation? ☐ No ☐ Yes If yes Type: ☐ Standard ☐ JIPS ☐ Sexual Offender		
Probation Officer:	Phone:	Fax:
Currently on Parole? ☐ No ☐ Yes		
Parole Officer:	Phone:	Fax:
Last time (date) Probation or Parole Officer attended CFT:		
Currently Detained? ☐ No ☐ Yes If yes, Date detained: Where: Next court Date: Release Date:		
If sexual offenses/sex offender treatment is the reason for the referral, attach a psychosexual assessment with recommendations and a statement by the current treating sexual behavior specialist regarding recommendations and treatment needs. Provide the police report(s) if available.		
Probation /Parole Officer's current recommendation for where the child's Juvenile Justice needs will best be served:		

SECTION E: Current Child Protective Services (CPS) Involvement ☐ No ☐ Yes		
Date of last CFT attendance by CPS Case Manager:		
When and why was the child removed from the home?		
What is the current case plan? ☐ Reunification with Family ☐ Kinship Placement ☐ Severance/Adoption ☐ Long term foster Care ☐ Independent Living		
If reunification or kinship placement is panned, are there any court ordered limits to family involvement?		
CPS Guardian's current recommendation for where this child's Care and Custody needs will best be met:		
If the child were to remain in the community, what does the CPS guardian believe will be needed to keep the child safe?		
If the child enters an HCTC, where does CPS plan to have the child live upon discharge when the treatment goals have been accomplished?		
SECTION F: Current Division of Developmental Disabilities (DDD) Involvement ☐ No ☐ Yes		
ALTCS Eligible: ☐ No ☐ Yes		
DDD Case Manager:	Phone:	Fax:
Date of last CFT attendance by DDD Case Manager:		
What services or supports are available or being provided by DDD to address the C/A's DD needs:		

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Supporting Documentation	
The following information (as applicable) should be sent with application or no later than 5 days from initial fax of application. Fax to Magellan Care Management at 1-866-568-6147.	
Attach Supporting Documentation (if applicable)	
Child/ Family Team (BH Services) Plan (last 3)	☐ Yes ☐ No ☐ N/A
Court Reports/Orders and/or Detention Incident Reports	☐ Yes ☐ No ☐ N/A
Individual Education Plan	☐ Yes ☐ No ☐ N/A
Police Reports and/or Probation/Parole Reports	☐ Yes ☐ No ☐ N/A
Psychiatric Evaluations and Last 3 psychiatric Progress Notes	☐ Yes ☐ No ☐ N/A
Psychoeducational Testing Report	☐ Yes ☐ No ☐ N/A
Psychological Evaluation	☐ Yes ☐ No ☐ N/A
Psychosexual Assessment (if completed)	☐ Yes ☐ No ☐ N/A
Safety and Crisis Plans	☐ Yes ☐ No ☐ N/A
Strengths Needs Cultural Discovery	☐ Yes ☐ No ☐ N/A
Summaries from any Treatment/Direct Support Agencies	☐ Yes ☐ No ☐ N/A
Mandatory – The following form must be completed Children's Provider Network Organization Medical Director Review Form Attachment A.	☐ Yes ☐ No ☐ N/A

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ATTACHMENT A: Children's Provider Network Organization Medical Director Review	
Once application is complete and faxed to Magellan, the application must also be faxed to the Child's PNO Medical Director for review. This form is to be completed ONLY by the Medical Director and faxed to Magellan Care Management at 1-866-568-6147.	
I have reviewed this application for (child or adolescent's name)_____ and recommend the following alternative to an OOH intervention: ☐ No recommendation at this time ☐ Alternate to an OOH intervention. Specify services required to meet clinical needs:	
☐ Support request for HCTC. (indicate the behavioral health treatment needs that cannot be met with community service(s)alone):	
_____ Name (Please print)	_____ Signature _____ Date
Phone:	Fax: