



**Request for Child/Adolescent Behavioral Health Inpatient Facility
or Behavioral Health Residential Facility Intervention**
Form 3.14.7

One of three decisions will be made within seven business days of receipt of a completed packet.
Agencies/providers requesting a Behavioral Health Inpatient Facility or Behavioral Health Residential Facility 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 Psychiatric Level of Care: <input type="checkbox"/> Behavioral Health Inpatient Facility <input type="checkbox"/> Behavioral Health Residential Facility | Requested by: <input type="checkbox"/> CPS <input type="checkbox"/> JPO <input type="checkbox"/> ADJC <input type="checkbox"/> Family Member |
| Is this funding of a current placement? <input type="checkbox"/> Yes <input type="checkbox"/> No | Is this funding for court-Ordered placement? <input type="checkbox"/> Yes <input type="checkbox"/> No |

Child/Adolescent Information

| | | | |
|--|---------------------------------------|-----------|-------------------------|
| Child/Adolescent Name: | DOB: | Age: | Social Security Number: |
| Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male | Ethnicity: | Language: | |
| Active T19/21: <input type="checkbox"/> Yes <input type="checkbox"/> No | AHCCCS Eligibility Verification Date: | | |
| Child/Adolescent's Current Location: <input type="checkbox"/> Home <input type="checkbox"/> Detention <input type="checkbox"/> ADJC Facility <input type="checkbox"/> CPS Shelter <input type="checkbox"/> CPS Group home <input type="checkbox"/> Hospital <input type="checkbox"/> CPS Foster Care home <input type="checkbox"/> Other Behavioral Health Out of Home Facility (please specify): | | | |
| If other than home, date placed: | School: | District: | |

Legal Guardian Information

| | |
|---|--|
| Name: | Contact Number: <input type="checkbox"/> Work: , ext: <input type="checkbox"/> Home: |
| Mailing Address: | |
| City: | State: Zip code: |
| Guardian's Primary Language: <input type="checkbox"/> English <input type="checkbox"/> 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 Diagnosis per Treating Psychiatric Provider (for Axis I and II Diagnosis 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 |
|------------|------|------------|--|
| | | | <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Poor |
| | | | <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Poor |
| | | | <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Poor |
| | | | <input type="checkbox"/> Full <input type="checkbox"/> Partial <input type="checkbox"/> Poor |

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

| Substance Class | Age of 1 st 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:

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

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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) Hospital
- Parent Partner/Family Support Partner School-Based Services Vocational Assessment/Training Level I Residential
- Behavioral Health Inpatient Facility Behavioral Health Residential Facility HCTC Specialty Therapy: Type:
- Other; (describe):

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

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

| Dates | | Length of Stay | Provider/Level of Care | Discharged To |
|-------|-----|----------------|------------------------|---------------|
| From: | To: | | | |
| From: | To: | | | |
| From: | To: | | | |
| From: | To: | | | |
| From: | To: | | | |

Evaluation of Current Services to Include Formal and Informal Supports

- Are the current community supports addressing the identified needs? Yes No
- If no, has the CFT increased intensity/frequency of services or tried different services to address the needs?
 Yes No If yes please describe:
- Has there been a recent evaluation by a psychiatric provider? Yes No
- 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:

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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 out-of-home, the clinical staff of the treating facility 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 treating facility with the aim of returning the child to outpatient treatment services 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's and the family's treatment needs.

- a. Residency Plan:
- b. Outpatient Services and Natural Supports (describe type and frequency):

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

3. Has the CFT reviewed or involved FSP or parent supports? Yes No

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



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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:

Out-of-Home Intervention (check level of care recommended):

- Behavioral Health Inpatient Facility
- Behavioral Health Residential Facility

Name (please print)

Signature

Date

Phone:

Fax:

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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 planned, 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 out-of-home psychiatric facility, 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 child or adolescent's disability 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) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Court Reports/Orders and/or Detention Incident Reports | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Individual Education Plan (mandatory for IEP placements) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Police Reports and/or Probation/Parole Reports | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Psychiatric Evaluations and Last 3 Psychiatric Progress Notes | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Psychoeducational Testing Report | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Psychological Evaluation | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Psychosexual Assessment (if completed) | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Safety and Crisis Plan | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Strengths Needs Cultural Discovery | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Summaries from any Treatment/Direct Support Agencies | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A |
| Mandatory – The following form must be completed Children’s Provider Network Organization Medical Director Review Form Attachment A. | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 Behavioral Health Inpatient Facility Behavioral Health Residential Facility (indicate the behavioral health treatment needs that cannot be met with community service(s) alone):

Name (Please print) Signature Date

Phone: Fax: