**HSCSN PRTF Medical Necessity Review Referral Form**

Health Services for Children with Special Needs, Inc. (HSCSN)

Admission to a Psychiatric Residential Treatment Facility

Medical Necessity Review Referral Form

Every child/youth who is referred for review of medical necessity for psychiatric residential level of care should be a part of an ongoing family-driven team-based process. The team should consider the strengths and needs of the child/youth and the family in order to determine what supports and services would meet the needs of the child/youth. After multiple meetings and attempts at community-based services, if the team comes to a consensus that psychiatric residential treatment would best meet the needs of the child/youth, then this referral form should be completed and submitted to HSCSN.

1. PLEASE COMPLETE THE REFERRAL FORM AND AUTHORIZATION TO USE OR DISCLOSE PROTECTED INFORMATION (SEE THE ATTACHED [DMH HIPAA-FORM 3- CYSD). SUBMIT THESE WITH ALL OTHER SUPPORTING DOCUMENTATION AS LISTED ON PAGE 2.
2. REFERRALS WHICH ARE ILLEGIBLE, INCOMPLETE, OR DO NOT HAVE REQUIRED SUPPORTING DOCUMENTATION WILL NOT BE REVIEWED BY THE PRTF REVIEW COMMITTEE. **IF THE REFERRAL PACKET IS INCOMPLETE, IT WILL BE SENT BACK TO THE REFERRING PARTY WITH FURTHER INSTRUCTIONS.**
3. THE REFERRAL FORM AND ALL SUPPORTING DOCUMENTATION SHOULD BE SENT ELECTRONICALLY TO h[authcentralintake@hscsn.org](mailto:authcentralintake@hscsn.org) or via fax to 202-721-7190. IF YOU NEED TO SEND THE DOCUMENTATION BY AN ALTERNATIVE METHOD, PLEASE CONTACT THE PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) COORDINATOR AT 202-495-7552.
4. ONCE A REFERRAL PACKET IS RECEIVED, THE PRTF COORDINATOR WILL REVIEW THE PACKET FOR COMPLETENESS. BASED ON THE INITIAL REVIEW OF THE PACKET, THE COORDINATION MAY REQUEST ADDITIONAL INFORMATION FROM THE REFERRING PARTY WHICH MUST BE PROVIDED WITHIN A SPECIFIED DUE DATE. THE COORDINATOR WILL THEN PROVIDE A CASE SUMMARY TO THE PRTF REVIEW COMMITTEE.
5. UNLESS ADDITIONAL, ESSENTIAL INFORMATION IS REQUIRED TO MAKE A DETERMINATION, THE PRTF REVIEW COMMITTEE WILL REVIEW THE CASE AND MAKE A MEDICAL NECESSITY DETERMINATION USING INTERQUAL CRITERIA.
6. WITHIN 1-2 BUSINESS DAYS OF THE DETERMINATION, THE PRFT COORDINATOR WILL PROVIDE THE WRITTEN DETERMINATION TO THE REFERRING PARTY WITH ANY ADDITIONAL RECOMMENDATIONS MADE BY THE REVIEW COMMITTEE, AND PROVIDE A COPY TO THE DEPARTMENT OF HEALTH CARE FINANCE (DHCF).

IF THERE ARE ANY QUESTIONS REGARDING THIS PROCESS,

PLEASE CONTACT THE PRTF COORDINATOR AT 202-495-7552.

**BELOW IS A LIST OF REQUIRED SUPPORTING DOCUMENTATION FOR**

**THIS REFERRAL FOR REVIEW OF MEDICAL NECESSITY FOR PRTF**

**Please check all that are included in the referral packet.**

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|  | **HSCSN Medical Necessity Review Referral Form** |
|  | **Authorization to Use or Disclose Protected Information (Use DMH-HIPAA FORM-3-CYSD)** |
|  | Parent/Caregiver **Authorization for Medical Necessity Review** for Psychiatric Residential Treatment (page 8 of referral) |
|  | **All Psychiatric Evaluations** (within last 90 days)-**REQUIRED** |
|  | **All Psychological Evaluations** (within last 2 years)-**REQUIRED** |
|  | **All Psycho-educational Evaluations** (within last 2 years) |
|  | **Diagnostic Assessment** (completed within last year, if Psychiatric and/or Psychological Evaluations are not available) |
|  | **Treatment Plan and Discharge Recommendations** (if youth is in a facility or hospital) |
|  | **Discharge Summaries** from last 2 Hospitalizations |
|  | **Psychosocial Evaluation/Summary-REQUIRED** |
|  | **Social Study** from Court Social Services (CSS) |
|  | **Recent Court** Reports (must include description of any recent offenses, judge, attorney, defense attorney) |
|  | **Current Plan of Care or Team Meeting Notes over last 6 months** (including sign-in sheets) |
|  | **Individualized Education Program** (if applicable)-**REQUIRED** |
|  | Any other information relevant to this review **(i.e., 504 plan, recent progress notes, other evaluations, etc.)** |

**Referral Packet completed by (print):**

Name/Title

**Signature:**  Date Click here to enter a date.

**Email:**  Phone:

***By signing below, I am certifying that the District agency/entity clinical team working with this child/youth believes that he/she meets medical necessity and this referral includes all of the above required documentation for this review:***

**Referral Agency Representative (print):**

Name/Title

**Signature:**  Date Click here to enter a date.

**Email:**  Phone:

**Supervisor** (print):

Name/Title

**Signature:**  Date Click here to enter a date.

**Email:**  Phone:

**Organization/Agency Affiliation:**

**PRTF Referral Form**

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| **Referred Youth’s Information** | | | | | | | | |
| Name (Last, First, Middle Initial): | | Date of Birth: | | | | | Gender:  Male  Female | |
| Address: (Current address, city, state, zip code) | | | | | | | | Phone#: |
| Primary Language Spoken: | | | | Secondary Language (if any): | | | | |
| The family reads and speaks English at home | | | | Family speaks a different language at home: | | | | |
| The family needs an interpreter: Yes  No | | | | If different language, please list: | | | | |
| Medicaid Eligible:  Yes  No  TBD | | | | If yes, please provide Medicaid #: | | | | |
|  | | | | Check One:  Fee For Service Managed Care  HSCSN | | | | |
| Race/Ethnicity: (If Hispanic/Latino, choose from Section B; all others choose from Section A)  **Section A: Section B:** | | | | | | | | |
| American Indian/Alaska Native | | | Mexican | | | | | |
| Asian | | | Puerto Rican | | | | | |
| Black or African American | | | Cuban | | | | | |
| Native Hawaiian or Other Pacific Islands | | | Dominican | | | | | |
| White | | | Central American | | | | | |
| Biracial (Specify): | | | South American | | | | | |
| Other (Specify): | | | Other (Specify) | | | | | |
| **Parent Information** (If parents are separated, include information for both parents) | | | | | | | | |
| Mother’s Name: (Last, First, Middle Initial) | | | | | | | | |
| Address: (Home address, city, state, zip code) | | | | | | | | |
| Home Phone#: | Work Phone #: | | | | | Other Phone #: | | |
| Email Address: | | | Best Time To Call: | | | | | |
| Primary Language Spoken: | | | Secondary Language (if any): | | | | | |
| Father’s Name (Last, First, Middle Initial | | | | | | | | |
| Address (Home address, city, state, zip code) | | | | | | | | |
| Home Phone#: | Work Phone #: | | | | | Other Phone#: | | |
| Email Address: | | | Best Time To Call: | | | | | |
| Primary Language Spoken | | | Secondary Language (if any) | | | | | |
| **Primary Caregiver/Legal Guardian Information** (if not parent) | | | | | | | | |
| Name: (Last, First, Middle Initial) | | | | | Relationship to Child/Youth: | | | |
| Address: (Home address, city, state, zip code) | | | | | | | | |
| Home Phone#: | Work Phone #: | | | | | Other Phone #: | | |
| Email Address: | | | Best Time To Call: | | | | | |
| Primary Language Spoken: | | | Secondary Language (if any): | | | | | |
| Legal Guardian: Yes  No If No, provide name: | | | | | | | | |

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| **Other Important Contacts** | | | | | | | | |
| If we cannot contact one of the parents or caregivers, please list the name of an additional involved contact person  (e.g., grandparent, adult sibling, aunt/uncle): | | | | | | | | |
| Name: | | Relationship to Youth | | | | | Phone#: | |
| Name: | | Relationship to Youth | | | | | Phone#: | |
| **Sibling Information** (attached additional sheet as needed) | | | | | | | | |
| Name (First & Last) | Gender  M/F | | Date of  Birth | | Relationship  To Youth | School/Grade | | Current Residence |
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| **School Information** | | | | | | | | |
| Local Education Agency (LEA): (for example, DCPS, Charter School, etc.) | | | | | | | | |
| School Name: | | | | | | | | |
| Current Academic Performance: | | | | | | | | Grade Level: |
| Regular Education (specify accommodations, if any): | | | | Special Education (attach Individualized Education Program)  Primary Disability Category: | | | | Other (specify): |
| Is the attendance of the youth an issue/concern?  Yes  No | | | | | | | | |
| If Yes, what has been done to address it: | | | | | | | | |
| **Teaming** | | | | | | | | |
| Team Meeting Notes or Plan of Care Attached  Yes  No | | | | | | | | |
| Has the team met routinely and adjusted the Plan of Care?  Yes  No If Yes, how often: | | | | | | | | |
| If No, please explain: | | | | | | | | |
| Teaming/Care Coordination provided by: | | | | | | | | |
| DC Choices Wraparound Process | | | | | | | | |
| Far Southeast Collaborative Child and Family Teaming  GA Avenue Collaborative Child and Family Teaming | | | | | | | | |
| DYRS Youth and Family Teaming  CSS Family Group Conferencing | | | | | | | | |
| Other (specify): | | | | | | | | |
| Name of Team Facilitator/Care Coordinator: | | | | | | | | |
| Is the team in consensus about referring this you to PRTF?  Yes  No  If No, identify the parties who disagree and why: | | | | | | | | |

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| **Current System Involvement and Team Members (Select all that apply)** | | | | |
|  | Contact Person | | Phone# | Email |
| Court Social Services (Probation) |  | |  |  |
| Department of Youth Rehabilitation Services |  | |  |  |
| Education |  | |  |  |
| Child and Family Services Agency |  | |  |  |
| Parent’s Rights Terminated:  Yes  No |  | |  |  |
| Special Education |  | |  |  |
| Mental Health Provider (agency name: ) |  | |  |  |
| Specialty Mental Health Provider:  (For example, CBI, MST, FFT, private therapist) |  | |  |  |
| Hospital |  | |  |  |
| Physical Health Care Agency/Clinic/Provider |  | |  |  |
| Substance Abuse Agency/Clinic/Provider |  | |  |  |
| Other (Please specify) |  | |  |  |
| Other (Please specify) |  | |  |  |
| **Current Living Situation of Youth** | | | | |
| Two Parent Biological Family | | Therapeutic Group Home | | |
| One Parent Biological Family | | Youth Shelter House | | |
| Two Parent Adoptive Family | | Runaway/Homeless | | |
| One Parent Adoptive Family | | Detention Youth Services Center  New Beginnings | | |
| Grandparent(s) | | Residential Treatment Center Name: | | |
| Other Relative’s Home | | Psychiatric Residential Treatment Facility Name: | | |
| Other Non-Relative’s Home | | Acute Care Inpatient Hospital: | | |
| Traditional Foster Care | | Sub-Acute Care Inpatient Hospital: | | |
| Therapeutic Foster Care | | Other (specify): | | |
| Traditional Group Home | |  | | |
| *Anticipated discharge date from above (if applicable):* | | | | |
| **Out of Home Placement Due to Family Court:** | | | | |
| Is placement related to Child Welfare?  Yes  No | | | | |
| Is placement related to Juvenile Justice?  Yes  No | | | | |
| **Family Court Involvement:** | | | | |
| Next Court Date: | | | | |
| Type of Hearing: | | | | |
| Name of Judge: | | | | |
| **During the Past 6 Months, was the Youth the Enrollee/Recipient**  **of any of the Following? (Select all that apply)** | | | | |
| Medicaid (Check one)  Fee For Service  Managed Care  Health Services for Children with Special Needs | | | | |
| TANF (public assistance):  Yes  No  Private insurance (specify): | | | | |
| Social Security Disability Income & Amount (SSI Benefits): | | | | |

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| **DSM Diagnosis Source (provided within last 12 months)** | |
| Which professional source made the diagnosis as indicated in the following information below? | |
| Child Psychiatrist  Licensed Clinical Social Worker  Child Psychologist | |
| General Psychiatrist  Nurse Practitioner  General Psychologist | |
| Licensed Professional Counselor  Other | |
| Name of Clinician: Date of Diagnosis: | |
| **DSM Diagnosis Information** | |
| **AXIS I: CLINICAL DISORDERS** (*Please list Axis 1 Primary Diagnosis first*.) | |
| **AXIS II: PERSONALITY DISORDERS, MENTAL RETARDATION** (*If any*) | |
| **AXIS III: GENERAL MEDICAL CONDITIONS** (*If any*) | |
| **AXIS IV: PSYCHOSOCIAL AND ENVIRONMENTAL PROBLEMS**  (*Select all that apply)* | |
| Problems with primary support group | Economic problems |
| Problems related to the social environment | Problems with access to health care services |
| Educational problems | Occupational problems |
| Other psychosocial and environmental problems | Housing problems |
| Problems related to interaction with the legal system/crime | Other (specify): |
| **AXIS V: GLOBAL ASSESSMENT OF FUNCTIONING (GAF)** | |
| **What are the problems within last 6 months that led to this referral for PRTF?**  **Check all that apply** | |
| Suicide-related problems (including suicide ideation, suicide attempt, self-injury) | |
| Depression-related problems (including major depression, dysthymia, sleep disorders, somatic complaints) | |
| Anxiety-related problems (including fears and phobias, generalized anxiety, social avoidance, obsessive-compulsive behavior, post-  traumatic stress disorder) | |
| Hyperactive and attention-related problems (including hyperactive, impulsive, attention difficulties) | |
| Conduct/delinquency-related problems (including physical aggression, extreme verbal abuse, non-compliance, sexual acting out, property damage, theft, running away, sexual assault, fire setting, cruelty to animals, truancy, police contact) | |
| Substance use, abuse, and dependence-related problems | |
| Adjustment-related problems (including changes in behaviors or emotions in reaction to a significant life stress) | |
| Psychotic behaviors (including hallucinations, delusions, strange or odd behaviors) | |
| Pervasive developmental disabilities (including autistic behaviors, extreme social avoidance, stereotypes, preservative behavior)) | |
| Specific developmental disabilities (including enuresis, encopresis, expressive or receptive speech and language delay) | |
| Learning Disabilities | |
| School performance problems not related to learning disabilities | |
| Eating Disorders (anorexia, bulimia, obesity) | |
| Trauma (community violence, school violence, complex trauma, domestic violence, medical trauma, natural disasters, neglect, physical  abuse, refugee and war zone trauma, sexual abuse, terrorism, traumatic grief) | |
| Other Problems (Please specify): | |

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| **CRITICAL INFORMATION FOR ELIGIBILITY**  **IMPORTANT: Eligibility factors are largely based on risk of out-of-home placement or hospitalization. Be explicit and detailed including the level of severity and frequency of the behaviors. *DC PRTF Admission criteria listed on page 9 of this referral form should be addressed here. Add additional pages if necessary.*** | | |
| **At-Home**: (examples: safety concerns for youth and/or family, rebellious, curfew violations, physical aggression, trauma) | | |
| **In School** (examples: attendance, suspension, altercations, weapons) | | |
| **In Community:** (examples: involvement with Crisis Services, Juvenile Justice involvement, substance abuse) | | |
| **Services Received within Last Year to Attempt to Stabilize Youth:**  **Please select all that apply and additional pages regarding outcomes if necessary** | | |
|  | Agency/Individual | Dates of Service |
| Inpatient Acute Hospitalization (s) |  |  |
| Inpatient Sub-acute Hospitalization (s) |  |  |
| Psychiatric Residential Treatment (anytime within last 5 yrs) |  |  |
| Individual Therapy (frequency: ) |  |  |
| Family Therapy (frequency: ) |  |  |
| Community Support |  |  |
| Community Based Intervention |  |  |
| Multi-Systemic Therapy |  |  |
| Trauma-Focused Cognitive Behavior Therapy |  |  |
| School Mental Health Services (specify type: ) |  |  |
| Day Treatment |  |  |
| One-on-One Staff (frequency/setting: ) |  |  |
| Special Education Services (IEP) |  |  |
| Other (specify) |  |  |
| Other (specify) |  |  |

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| **Justification for PRTF Level of Care**  **Indicate why lower levels of service have not been successful in stabilizing this youth**  **and why he/she requires PRTF to meet his/her needs.** |
|  |
| **Expectations from PRTF**  **Please identify the goals of treatment in PRTF, the anticipated length of stay**  **in PRTF, and anticipated plans upon discharge.** |
| Goals: |
| Anticipated Length of Stay: |
| Anticipated Discharge Plans: |
| **Youth & Family Strengths**  **Describe youth and family strengths that will assist in keeping the youth at home and within the**  **community; or, what strengths will assist in the successful return of the youth from placement.** |
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**To Be Completed by Parent/Legal Guardian Only:**

The Department of Mental Health recognizes that families have a voice and choice during the process for reviewing for medical necessity for treatment in a Psychiatric Residential Treatment Facility (PRTF). I, as the parent/caregiver, understand that my family’s strengths and needs were identified prior to this review. I will continue to work with my child/family team to help determine what will work best for my child and family.

Name of Parent or Legal Guarding (Print):

Signature:  Date: