 

|  |
| --- |
| APPLICATION FOR INTENSIVE TEMPORARY RESIDENTIAL TREATMENT |

|  |
| --- |
| **DEMOGRAPHICS** |
| **MaineCare ID** | **Soc. Sec. No.** | **First Name** | **Last Name** | **DOB** | **Age** |
|       |       |       |       |       |       |
| **Youth Is In Child Welfare Custody Yes      No****Is DOC Involved? Yes      No** | **District** |
| **Legal Guardian Name/ Address** | **Legal Co-Guardian Name/ Address** |
| Name:       Address:       Phone:       Fax:      Email Address:   | Name:       Address:       Phone:       Fax:        Email Address:  |
| **CASE MANAGER** |
| Name:      Agency:      Address:      :  | Phone:      Email:      Fax:       | Supervisor Name: Email:       |       Phone:       |
| **Current Location:** [ ]  Home/Foster Home [ ]  Psychiatric Hospital   [ ]  ED [ ] Residential Treatment [ ]  Long Creek [ ]  Shelter [ ]  Crisis Unit [ ]  Other:       |
| **Is this a transfer ITRT Request?** [ ]  Yes [ ]  No **If yes, please skip to the end of this application and follow those directions. Do not fill out the rest of this application.**  |
| **EDUCATION** |
| Most Recent School Attended:      Does the youth have either  An IEP? YES     NO     **OR** A 504 Plan? YES    NO      |
| **MEDICATIONS** |
| **Is the child presently taking medications to address Mental Health Impairment?**[ ]  No Please provide documentation explaining reason child does not receive medication or if not indicated. [ ]  Yes Name and date of document with current medications:        |
| **ELIGIBILITY CRITERIA FOR LEVEL OF CARE** |
| **Diagnoses given within the past 6 months** [ ]  Yes Please list the title and date of document(s) that support this criteria:      [ ]  Full Scale IQ (Required for Youth With Intellectual Disabilities)    Date Given:      Provider:     |
| **CAFAS , GAF, CHAT within the past 10 days**[ ]  Yes Please list the title and date of document(s) that support this criteria:       |
|  **Does the child demonstrate a current need for Therapeutic Treatment or Availability Of A Therapeutic On-Site Response On A 24 Hour Basis** [ ]  No[ ]  Yes Please list the title and date of document(s) that support this criteria:       |
| **Even with intensive community intervention, including services and supports, there is Significant Potential That The Child Would Be Hospitalized or there is a clear indication that the child’s condition would significantly Deteriorate And Would Require A Higher Level of service than can be provided in the home and community.**[ ]  No [ ]  Yes Please list the title and date of document(s) that support this criteria:       |
| **Has the child displayed Significant Recent Aggression (within the past 2 months) across multiple environments or severe enough within one environment to have caused serious injury or there is significant potential of serious injury to self or others?** [ ]  No[ ]  Yes Please list the title and date of document(s) that support this criteria:       |
| **Has the child demonstrated Recent (within the past 2 months) HOMICIDAL IDEATION (*including intent, plan and means*) with risk of harm to self or others?** [ ]  No[ ]  Yes Please list the title and date of document(s) that support this criteria:       |
| **Has the child demonstrated Recent (within the past 2 months) SUICIDAL IDEATION (*including intent, plan and means*) with risk of harm to self?** [ ]  No[ ]  Yes Please list the title and date of document(s) that support this criteria:       |
| **Has the child demonstrated symptoms of mental illness, mental retardation, or pervasive developmental disorders (within the past 2 months) that have resulted in the Inability To Care For Self To A Developmentally Appropriate Level, even with home and community supports?** [ ]  No[ ]  Yes Please list the title and date of document(s) that support this criteria:       |
| **Has the child not responded to a less restrictive level of care OR would have significant risk of harm to self or others if a less restrictive setting were attempted?**[ ]  No[ ]  Yes Please list the title and date of document(s) that support this criteria:       |
| **TREATMENT HISTORY** |
| Please review the following services and identify those which are currently provided and/or have been in the past **12 months** |
| **SERVICE** | **START** | **END** | **INDIVIDUAL PROVIDER AND AGENCY AFFILIATION**List provider agency along with name of individual providing service. | **FREQUENCY** |
| **Intensive Outpatient (IOP)** |       |       |       |       |
| **Foster Care A and B** |       |       |       |       |
| **Any Services Not Funded By Maine Care** |       |       |       |       |
| Did **any** of the child’s behavioral health services close abruptly or prior to treatment goals being completed? If yes, please list the service and explain.       |

**REQUIRED DOCUMENTATION, ACTION STEPS and NOTIFICATIONS FOR ITRT REFERRALS**

In order for KEPRO to authorize treatment in a residential facility, it is necessary to submit clinical documentation that supports the child meeting the medical eligibility criteria listed in the Maine Care Benefits Manual Chapter II Section 97.02, Child and Adolescent Intensive Behavioral Health Treatment in a Residential Setting.

Prior to submitting an ITRT application, please review the following documents and complete appropriate notifications with the caregiver and other providers:

[ ]  Residential Consult Guide with Family and Youth

[ ]  [https://www.maine.gov/dhhs/ocfs/cbhs/provider/documents/section97itrtconsultguide.pdf](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.maine.gov%2Fdhhs%2Focfs%2Fcbhs%2Fprovider%2Fdocuments%2Fsection97itrtconsultguide.pdf&data=04%7C01%7CJamie.Bartlett%40maine.gov%7Cb2613e3926224eeab2b308d8a5afd877%7C413fa8ab207d4b629bcdea1a8f2f864e%7C0%7C0%7C637441521946768947%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=inAtx3oCFhZodjK8iNxpoLm3TCU0ZJx2yguaLWTIxg4%3D&reserved=0)

[ ]  ITRT Brochure with Family and Youth

[https://www.maine.gov/dhhs/ocfs/cbhs/provider/documents/ITRTbrochure10.21.2020.pdf](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.maine.gov%2Fdhhs%2Focfs%2Fcbhs%2Fprovider%2Fdocuments%2FITRTbrochure10.21.2020.pdf&data=04%7C01%7CJamie.Bartlett%40maine.gov%7Cb2613e3926224eeab2b308d8a5afd877%7C413fa8ab207d4b629bcdea1a8f2f864e%7C0%7C0%7C637441521946778903%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C1000&sdata=IoQgtKhhRDmR00xvNTMpGN%2BwtZ%2BjuG6%2BueIzV7Vce8E%3D&reserved=0)

[ ]  Educational Planning and Notification for ITRT with Guardian

<https://www.maine.gov/dhhs/ocfs/cbhs/provider/itrt.html>

**\*Please note timeframes for required documents. Documents submitted outside of these timeframes will not be used in determining eligibility for residential treatment.**

[ ]  Diagnosis list provided by the most current licensed mental health provider with in last **6 months**.

[ ] GAF, CAFAS OR CHAT score completed with in **10 days** of the application date. Entire scoring tool must be submitted for CAFAS/CHAT. Written justification must be submitted for GAF.

[ ]  Treatment progress notes from ALL mental health providers from the past **2 months only** (individual clinicians, psychiatry, HCT, RCS, Case management, crisis programs, hospital, therapeutic foster care, etc.)

[ ]  Mobile Crisis assessments from the past **2 months**

[ ]  Admission and Discharge summaries from ALL mental health treatment providers over the past **12 months**

[ ]  **Physician or PCP letter provided**

Maine Care rule (97.02) requires that a physician or primary care provider must document in writing that this model of service is medically necessary.  Please indicate here that this physician or PCP letter is provided in this document, and indicate the name of the writing physician.  Physician/PCP letter provided.  Name of physician/PCP:

 Any incident reports from the past **2 months** from any provider (police, crisis, hospital, school, animal control, fire department, therapeutic foster care, etc.) that will show frequency, intensity and duration of symptoms that may require this level of care.

**[ ]** The most recent psychological, psychiatric or neuropsychological evaluation.

***\**Please DO NOT send treatment or crisis plans, Individualized Educational Plans or Report cards**

**REQUIRED NOTIFICATIONS ANY TIME A YOUTH IS PLACED IN RESIDENTIAL TREATMENT**

It is the responsibility of the guardian to notify the following funding sources when a child enters or leaves ITRT. Failure to do so may result in repayments being charged to the guardian.

**[ ]** Financial Resources: Social Security Income , Adoption Subsidy, Maine Care and/or Private Insurance

**[ ]** Other funding sources (Parental death benefits, trust funds, etc.)

 Describe:

Note: These sources are specific to the child, not other family members

**[ ]** It is the responsibility of the case manager to notify the Sending School or SAU and DOE any time a youth is being admitted to a residential facility. SAC.DOE@maine.gov If you are unsure who the sending school is, contact DOE at SAC.DOE@maine.gov

**REQUIRED ACTION STEPS TO ENSURE APPROPRIATE EDUCATIONAL PLANNING WHILE OUT OF HOME**

Education planning is a vital part of the process when children must be placed outside of their home. Schools must be included in the discussion when there is consideration of applying for residential treatment. Their ability to serve a child can be impacted when the child is located out of their district. Appropriate school staff must be included in conversations about any potential out of home placements. School teams are very creative when developing individualized education opportunities, and they often have an array of options to consider. When youth are being considered for treatment in an out of state setting, additional planning is required. Formal notification that admission will occur must be provided to the school as soon as an admission date is available.

* 1. Include current school in conversations about the potential need for residential treatment.
	2. Notify current school if ITRT is approved

**IF THE YOUTH IS CURRENTLY IN A CORRECTIONAL FACILITY:**

**[ ]** In addition to clinical information from the facility, please provide the clinical documentation listed above for the 2 months prior to the youth entering the facility.

**REQUEST FOR TRANSFER ITRT**

**Obtain clinical letter from current PNMI Clinician. This letter must include the following:**

1. Youth’s current diagnosis and GAF
2. A description of recent behaviors and symptoms that have required the need for alternative treatment. Please provide an explanation of why the youth can no longer be served by the agency.
3. Current specific treatment recommendations for the youth and family

-If you have access to Atrezzo complete the request at this

 link: <http://www.qualitycareforme.com/services/intensive-temporary-residential-treatment/>

-If you don’t have access to Atrezzo provide the clinical letter to Kepro **via secure email** (preferred) at IntakeME@kepro.com or fax to 866-325-4752: Call Kepro to confirm receipt of the letter 1-866-521-0027.

**KEPRO**

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

**Member Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ SSN: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize

(name and address)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(name and address of organization and/or person making disclosure)

to disclose to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and

(name and address of organization and/or person receiving information)

authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(name and address of organization and/or person disclosing or re-disclosing information)

to disclose to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(name and address of organization and/or person receiving disclosed or re-disclosed information)

**The following information:**

\_\_\_\_ Medical history, examination reports, \_\_\_\_ Laboratory reports \_\_\_\_ Reports of participation and progress and treatment

 and medications \_\_\_\_ Prescriptions \_\_\_\_ Discharge plans

\_\_\_\_ Operation reports \_\_\_\_ Consultations \_\_\_\_ Treatment or tests

\_\_\_\_ X-ray reports \_\_\_\_ Diagnosis \_\_\_\_ Copies of all other reports

\_\_\_\_ HIV test results \_\_\_\_ Results of drug screens \_\_\_\_ Mental health records, psychiatric, social,

\_\_\_\_ Fitness for duty concerns \_\_\_\_ Job performance functions psychological, and other allied health evaluations

\_\_\_\_ Alcohol, drug abuse reports \_\_\_\_ Hospital records, reports, dates of hospitalization and discharge

\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose(s) or need(s) for release:**

\_\_\_\_ Ongoing diagnosis, treatment planning, social, vocational, fiscal or educational planning

\_\_\_\_ Determining the appropriateness of services being provided and coordination of diagnostic evaluation, treatment planning and/or medical, social, vocational and/or psychological service delivery

\_\_\_\_ Rehabilitation case management of medical condition as a result of a workers' compensation injury

\_\_\_\_ Claims appeal or claims processing

\_\_\_\_ For any lawful purpose

\_\_\_\_ Other

**This authorization includes the types of information set forth above generated until the date of signature AND subsequently if generated before: (Provide date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

I understand that individually identified health information (“IIHI”) is protected under Federal and/or State confidentiality law. I further acknowledge that the information to be released was fully explained to me and this authorization is given of my own free will. I may withdraw this authorization to disclose IIHI at any time by written revocation except to the extent that the program or person that is to make this disclosure has acted in reliance on it. Upon revocation of this authorization, further release of IIHI authorized by this shall cease immediately. If not previously revoked, this authorization will terminate upon \_\_\_ year(s) from the date written on this form. A file copy is considered equivalent to the original.

**I understand that if the organization authorized to receive the information is not a health plan or health care provider, or a contractor thereof, the released IIHI may no longer be protected by federal privacy regulations. I understand that my health care and payment for my health care will not be affected if I do not sign this form. I understand that KEPRO will [not] receive financial or in-kind compensation in exchange for using or disclosing the IIHI described above.**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent, Guardian or Authorized Representative, Date

(if required, and relationship)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Child Welfare Guardian if in State Custody Date

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient is: \_\_\_ Minor \_\_\_\_ Incompetent \_\_\_\_Deceased

Legal Authority: \_\_\_ Parent or Legal Guardian \_\_\_\_Next of Kin of Deceased

**The person signing this authorization is entitled to a copy.**

**TO THE RECIPIENT OF CONFIDENTIAL INFORMATION: PROHIBITION ON REDISCLOSURE.** If the information disclosed to you relates to alcohol and other substance abuse treatment, this information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecue any alcohol or other substance abuse patient.

