Montana Medicaid Youth Continued Stay Request Authorization Form
Psychiatric Residential Treatment Facility (PRTF)

Please type or print clearly. Processing may be delayed if information submitted is illegible or incomplete.

☐ (124) PRTF Services

Request Submitted By			
It is recommended that a licensed or a supervised in-training mental health professional complete the authorization request, however it is not required.			
FIRST NAME:		**LAST NAME:**	
CREDENTIALS: ☐ RN ☐ LCSW ☐ LPC/LCPC ☐ Licensed Psychologist ☐ MD ☐ Other:			
PHONE:	**EXT:**	**FAX:**	**EXT:**

Youth Information	
NAME:	**MEDICAID NUMBER:**
ADMIT DATE:	**SSN:**

Responsible Party who receives determination notification (List CPS worker or probation officer when applicable.)			
NAME:	**PHONE NUMBER:**		
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**
RELATIONSHIP TO YOUTH: ☐ Parents ☐ Government Agency ☐ Other Relative:			

Responsible party is the person authorized to consent for medical treatment.

Facility Information				
NAME:				
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**	
PHONE NUMBER:	**FAX NUMBER:**	**PROVIDER NUMBER:**	**NPI NUMBER:**	**TAXONOMY:**
NUMBER OF DAYS REQUESTED:	**START DATE:**			

To transmit request information:
Fax: 1-800-639-8982
Phone: 1-800-770-3084

Clinical Information	
ANY CHANGES IN DSM V DIAGNOSIS:	
CODE:	DESCRIPTION:
CODE:	DESCRIPTION:
DATE OF PHYSICIAN'S INITIAL ADMISSION ASSESSMENT TO FACILITY:	

Mental Status:

CONTINUED STAY CRITERIA 1 REQUIRES YOUTH TO CONTINUE TO MEET ALL ADMISSION CRITERIA 1 THROUGH 6 BELOW.

Admission Criteria 1, 2, & 3: Describe the youth's symptoms and behaviors associated with their emotional disturbance that are so severe and persistent that they require 24-hour treatment under the direction of a physician:

Admission Criteria 4: Describe how the PRTF level of care can reasonably be expected to improve the youth's condition and why a less restrictive level of care is insufficient to meet the youth's severe and persistent treatment needs:

Admission Criteria 5: Describe the extent of active participation by the legal guardian and pre-admission caregivers in the treatment plan (If involvement is limited, specify why.):

Admission Criteria 6: Is youth a student with disabilities? Is an IEP in place? Do services meet IDEA and state special education requirements? Describe how the educational services and programs are meeting the youth's educational needs:

Continued Stay Criteria 2: Was the youth evaluated by a physician within 24 hours of admission?

Continued Stay Criteria 3: Identify progress youth has made and is likely to make toward treatment goals, using objective behavioral measurements and timeframes:

Continued Stay Criteria 4: Describe, if appropriate, the youth and family's cooperation with and progress toward treatment goals:

Identify the number of Time-Outs, Seclusion, Physical Restraints, include the dates and description of precipitating events:					
PRECAUTIONS:	☐ Suicide	☐ Aggression	☐ Elopement	☐ Other	
INTERVALS:	☐ q15	☐ q30	☐ q 1 hour	☐ Routine	☐ Other

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Identify the number of Critical Incidents (running away, sexual acting out, fighting), include the dates and description of precipitating events:

Current Medications:		
PRESCRIBING PHYSICIAN:		
Type of Medication	**Dosage**	**Start/End/Change Date (REQUIRED)**
IS YOUTH COMPLIANT? ☐ Yes ☐ No		

Current Treatment Plan/Goals:

Family Therapy (include dates and outcome):

Groups/Activities (describe participation):
Discharge Plan (include Estimated Discharge Date, Anticipated Discharge, Location, and Services, and explanation for any changes in Discharge Date/ Plan):

Check the following box to indicate you understand you are required to contact the Magellan Medicaid Administration's Regional Care Coordinator (RCC) to participate in this youth's treatment team meetings or the youth's therapist is required to contact the RCC to update them on youth's treatment, at a minimum of, every 30 days.
☐ Yes, I understand we are required to contact this youth's RCC every 30 days.

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Facility-Based Team Certification of Need for Continued PRTF Services

Client Information		
FIRST NAME:	MIDDLE NAME:	LAST NAME:
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	
MAILING ADDRESS:		
CITY:	STATE:	ZIP CODE:

Facility Information
PROVIDER NAME:
MEDICAID (OR NPI) PROVIDER NO:
RECERTIFICATION: A physician acting within the scope of practice as defined by State law must recertify for each recipient that inpatient services in a PRTF are needed.

Comments:

PRINT/TYPE NAME OF PHYSICIAN TEAM MEMBER

TITLE

SIGNATURE OF PHYSICIAN TEAM MEMBER

DATE

Magellan Medicaid Administration's Use Only			
APPROVED:	FROM:	THROUGH:	
DENIED:	FROM:	THROUGH:	
REVIEWER SIGNATURE:			DATE:

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