Montana Medicaid Youth  
In-State Psychiatric Residential Treatment Facility (PRTF) Denial Letter

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

In-state PRTFs, complete Sections I – IV.

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| --- | --- | --- | --- | --- | --- |
| I. Youth Information | | | | | |
| NAME: | | | | | |
| ADDRESS: | | CITY: | | STATE: | ZIP: |
| DOB: | SSN: | | proposed ADMIT DATE: | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| II. Referring Party Information | | | | | | | |
| NAME | | | | | | | |
| ADDRESS: | | | CITY: | | | STATE: | ZIP: |
| RELATIONSHIP TO youth: | Parent | Guardian | Agency | Other |  | | |

| III. Verification of Unavailability by In-State PRTF |
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| 1. This youth meets admission criteria for this facility; however, there is no bed available. Specify date when bed will be available: |
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| 2. This youth meets admission criteria for this facility; however, based on the current unit milieu, we are unable to admit youth at this time. Check all the following criteria that apply. Specify date when bed will be available: |
|  |
| a. Moderate violence/physical aggression. |
| b. Moderate suicide risk. |
| c. Developmental disability. |
| d. Moderate sexually reactive or sex offending behavior **(specify below)**: |
|  |
| e. Youth’s sibling is a resident. |
| f. Other **(specify below)**: |
|  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 3. This youth does not meet admission criteria for this facility for the following reasons (check all that apply): | | | | |
|  | a. | History of multiple PRTF placements without a clear response to a variety of treatment approaches in these settings. Youth unlikely to respond to treatment at, or benefit from, admission to this facility. | | |
|  | b. | Severe violence/physical aggression means a series of physical assaults without response to therapeutic intervention. Facility cannot assure safety of youth and/or staff and peers. | | |
|  | c. | Disregard for limit settings by staff, requiring 1:1 staffing more than 75% of the time to maintain safety of persons and property. | | |
|  | d. | Minimal response in reducing severe psychiatric symptoms after multiple therapeutic trials of psychotropic medications | | |
|  | e. | Severe suicide risk based on multiple suicide attempts in the last 6 to 12 months | | |
|  | f. | Established pattern of antisocial behavior with no documented response to treatment | | |
|  | g. | Florid psychosis, organic personality symptoms, or severely regressed behavior that has not responded to medical or psychological treatment **(specify symptoms and/or diagnosis)**: | | |
|  | | | | |
|  | h. | Primary presenting problem is chemical dependency (CD) without prior substance abuse treatment and inpatient CD treatment is indicated | | |
|  | i. | Developmentally disabled, IQ, neuropsychological deficits or level of functioning is too low to benefit from treatment **(specify below)**: | | |
|  | | | | |
|  | j. | Medical condition requiring specialized services or care beyond the capacity of the facility to address or manage **(specify below)**: | | |
|  | | | | |
|  | k. | One or only presenting problem is sexually reactive or sex offending behavior **(specify below)**: | | |
|  | | | | |
|  | l. | Autism Spectrum Disorder **(specify below)**: | | |
|  | | | | |
|  | m. | Fire Setting Behavior | | |
|  | n. | Elopement Risk | | |
|  | o. | Fetal Alcohol Spectrum Disorder **(specify below)**: | | |
|  | | | | |
|  | p. | Neuropsychiatric Disorder **(specify below)**: | | |
|  | | | | |
|  | q. | Age Inappropriate **(specify below)**: | | |
|  | | | | |
|  | r. | Other (Specify): | | |
|  | | | | |
| 4. Check the box if the following circumstances apply: | | | | |
|  | a. | Youth is in the custody of Child and Family Services Division | | |
|  | | Temporary | Permanent | Unknown |
|  | b. | Treatment is Court Ordered | | |

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| 5. Additional Comments: |
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| IV. Admissions Coordinator Completing Form | | | | | | |
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|  |  | **ADMISSIONS COORDINATOR** | |  | **DATE** |  |
| iN-sTATE prtf nAME: | | |  | | | |

| IV. Name of Out-of-State PRTF Submitting Form to Magellan Medicaid Administration |
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Note: This completed, signed document must be forwarded to the out-of-state PRTF within three business days. If this document is over 30 days old from the anticipated out-of-state PRTF admission date, a new document must be obtained from the In-state PRTF.