90-Day Review of Suitability of a Child for Out-of-State Residential Treatment

Revised: November 2017

Child Information		
NAME:	**MEDICAID NUMBER:**	**SOCIAL SECURITY NUMBER:**
DATE OF BIRTH:	**GENDER:** ☐ Male ☐ Female	
COUNTY OF ORIGIN:	**CIRCUIT:**	**AREA:**
CURRENT MEDICATIONS:		
Point of Contact (POC) Contact Information		
NAME:	**PHONE NUMBER:**	**FAX NUMBER:**
CURRENT MENTAL HEALTH ISSUES, TREATMENT PROGRESS		
DESIRED TREATMENT OUTCOME		
CURRENT TREATMENT DSM-5 DIAGNOSIS (INCLUDE ICD-10 CM CODES):		
Prescribing Physician at Facility		
NAME:	**PHONE NUMBER:**	

Child's Current Out of State Placement Location			
NAME OF TREATMENT FACILITY:			
PLACEMENT TYPE: ☐ In-Patient ☐ STGH ☐ Other:			
CONTACT REPRESENTATIVE AT FACILITY:	**CONTACT REPRESENTATIVE PHONE NUMBER:**		
CONTACT REPRESENTATIVE E-MAIL ADDRESS:	***VIDEO CONFERENCING INVITE WILL BE SENT TO THE E-MAIL PROVIDED TO THE LEFT**		
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**

Community Based Care Caseworker			
NAME:	**PHONE NUMBER:**	**EMAIL ADDRESS:**	
ADDRESS:	**CITY:**	**STATE:**	**ZIP:**

Guardian Ad Litem	
NAME:	**EMAIL ADDRESS:**
PHONE NUMBER:	**FAX NUMBER:**

Attorney Ad Litem	
NAME:	**EMAIL ADDRESS:**
PHONE NUMBER:	**FAX NUMBER:**

CHECKLIST OF REQUIRED FACILITY DOCUMENTS THAT MUST BE PROVIDED TO THE QUALIFIED EVALUATOR
☐ CURRENT TREATMENT PLAN
☐ CURRENT MEDICATION LOGS
☐ MENTAL HEALTH TREATMENT HISTORY
☐ COURT INFORMATION: ☐ PLACEMENT ORDER, ☐ OTHER
☐ INDIVIDUAL EDUCATION PLAN
☐ PSYCHOLOGICAL, PSYCHIATRIC, PSYCHOSOCIAL, PSYCHOSEXUAL EVALUATIONS
☐ PROVIDER CLINICAL NOTES, MULTIDISCIPLINARY TEAM SERVICE PLAN, INCLUDING IMPLEMENTATION RESULTS
☐ DJJ INFORMATION (DJJ, JDC, PROBATION, ETC.)
☐ OTHER (PLEASE SPECIFY):

Note: Referral Cannot Be Processed if Information Submitted is Illegible or Incomplete.

Magellan of Florida
To transmit request information:
Fax: 1-888-656-6823
Phone: 1-800-562-4059

We believe that _____, a child in the custody of the Department of Children and Families/CBC, is emotionally disturbed and may need residential treatment, in accordance with the Child and Family Operating Procedure No. 170-11 (CFOP 170-11).

I certify the referral form and package are complete and that all information will be provided to the Qualified Evaluator upon assignment.

SIGNATURE OF POINT OF CONTACT (POC) **DATE**

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