90-Day Review for Child placed Out-of-State for
Residential Treatment – Referral Form

Revised: October 16, 2019

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| 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: | EMAIL: |
| Current Mental Health Issues, Treatment Progress |
|  |
| **DESIRED TREATMENT OUTCOME** |
|  |
| CURRENT Treatment DSM-5 Diagnosis (includE ICD-10 CM codes): |
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|  |  |
|  |  |
|  |  |
| 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 |
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| [ ]  current treatment plan  |
| [ ]  current medication logs |
| [ ]  Mental health treatment history |
| [ ]  Court Information: [ ]  placement Order, [ ]  other  |
| [ ]  Individual Education Plan |
| [ ]  Evaluations: [ ]  Psychological, [ ]  Psychiatric, Psychosocial, [ ]  Psychosexual  |
| [ ]  Provider Clinical Notes, [ ]  Multidisciplinary team service plan, [ ]  including implementation results |
| [ ]  DJJ Information (DJJ, JDC, Probation, etc.) |
| **[ ]** Other (please specify):      |

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.

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|  |  |  |
| Signature of SPOA |  | Date |