Application for Residential Treatment Center Placement

Directions: Residential treatment centers (RTCs) are used to treat children and adolescents up to 21 years of age with mental disorders. The referring mental health provider must complete this application. In addition, submit any **available** supporting documentation (such as reports listed on the last page) with the application. Residential treatment center (RTC) placement cannot be considered without documentation of treatment, including outpatient intensive measures (multiple weekly visits), family therapy and/or acute inpatient admissions. Health Net Federal Services, LLC (HNFS) will process the request once the provider and family packets have been fully completed and received. Incomplete or illegible documentation will result in a processing delay of this request.

For questions on the RTC benefit, or assistance completing this form, please contact 1-844-866-WEST (9378). Submit this application and all supporting documentation via fax to 1-844-818-9289.

General Information

Date of request:	
Patient Information	
Name:	Patient date of birth:
Address:	
Sponsor name:	Sponsor Social Security number:
Custodial Guardian Information	
Name:	Address:
Home telephone number:	Work telephone number:
Requested RTC Facility Information	
Name:	Telephone number:

Current Condition

Current Diagnosis

_____

_____

_____

Symptomatology Checklist
(As applicable to current condition)

- ☐ Chronic and persistent danger to self or others
  - ☐ Fire setting
  - ☐ Self-mutilation
  - ☐ Runaway (longer than 24 hours)
  - ☐ Daredevil/impulsive behavior
    - Specify: _____
  - ☐ Sexually inappropriate/aggressive/abusive
  - ☐ Unmanageable behaviors
    - ☐ Angry outbursts/aggression
    - ☐ Psychotic symptoms
      - Specify: _____
  - Present greater than six months: ☐ Yes ☐ No
  - Expected to persist: ☐ Yes ☐ No
- ☐ Persistent violation of court orders
- ☐ Habitual substance use
  - ☐ Anxiety with associated symptoms increasing
  - ☐ Depressed/irritable mood and associated symptoms increasing
  - ☐ Manic/hypomanic and associated symptoms increasing
  - ☐ Psychotic symptoms increasing

Description of current condition including mental status and behavioral symptoms for which residential treatment might be needed (include explanation of all behaviors checked above):

Provide clinical justification why a lower level of care cannot be used, including history of local higher intensity of care and availability:

Living Situation

Barriers to being managed in the community (including why he/she cannot be managed at home and/or outpatient, etc.):

Community or military agencies involved in working with this patient or with the family (include court/legal history, social services, family advocacy, school system, etc.):

Medications (include all current medications):

Medication	Dosage	Frequency	Start Date

Treatment (start with most recent):

Type of Service (individual, group, family, partial hospitalization, inpatient)	Provider/Facility Name	Approximate Start/Admission Date	Outpatient Services Frequency (daily, weekly, etc.)

Patient's response to current treatment program, indicating what aspects have been effective and what aspects have been ineffective:

Provider Certification

This is to certify I am rendering care to this patient, the above statements are true and appropriate, and signed releases for the information provided to Health Net have been obtained. It is my recommendation this child be admitted to a residential treatment center.

Provider name:	
Provider address:	
Provider phone:	Fax:
Tax ID number:	

(Provider Signature and Credential) (Date)

Supporting Documentation

To assist in determining necessity for residential treatment placement, please include the following clinical documentation as available/applicable:

- ☐ Family/social history
- ☐ Psychiatric/clinical evaluation (including presenting problem, diagnosis, treatment needs, prognosis)
- ☐ Current psychological evaluation (including testing)
- ☐ Educational assessment with levels of academic achievement
- ☐ Physical and neurological examination results
- ☐ Discharge summaries from previous inpatient and outpatient treatment