

## REFERRAL AND ADMISSION PROCESS

### SPECIAL C&A STATE CONTRACTED SERVICES FOR YOUTH IN PARENTAL CUSTODY and WHO ARE NOT MEMBERS OF A CARE MANAGEMENT ORGANIZATION (CMO):

#### MAXIMUM ROOM, BOARD, and WATCHFUL OVERSIGHT

**Maximum Room, Board, and Watchful Oversight** is a short-term out-of-home placement option for youth who are enrolled with a Core Service Provider, meet the Core Services Customer definition, and are not able to remain in their home communities because of significant behaviors that cause them to be at risk for more intensive alternatives. These at risk factors include:

- anti-social behaviors
- delinquent behaviors,
- sexual reactive behaviors
- significant safety issues related to behaviors that cannot be managed in the home even with intensive community supports.

Youth enrolled in Core Services who are appropriate for this service are also those who need a step-down program when they are discharged from a PRTF, state hospital, or Crisis Services Program as a transition back to their home communities. It is also for youth who need structure and supervision out of their home so that the parents or legal guardians can receive the training and skill development in parenting and behavior management techniques needed for the child to live in the community.

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The Referral Process:

1. The Core Service Provider assesses the child's treatment needs and makes treatment recommendations and develops an individual treatment/resiliency plan and submits a MICP registration information form to APS. The treatment options or support services that the Core Services Provider may recommend are the following:
  - Core Services , including special consumer support services
  - Intensive Family Intervention
  - Crisis Stabilization Services
  - PRTF
2. The Core Services Provider works with the Parent/Legal Guardian to explore and exhaust all community services and supports in the mental health/addictive diseases programs and in the wider child-serving delivery system, including the school, child-welfare, and other supports. The Core Service Provider documents this process.

3. If the Parent/Legal Guardian and Provider believe that Maximum Room, Board, and Watchful Oversight is needed, the Provider begins collecting documentation for the Special Contracted Services Application package and schedules a meeting with the Local Inter-Agency Planning Team (Planning Team). The Special Contract Services Application consists of the following items:
  - MPI
  - Social History
  - Psychological Evaluation
  - Signed Educational form
  - IEP if indicated
  - Parental Agreement Form signed by parent
  - Case Management Agreement Form
  - Placement History Form
  - Community Care Plan
4. The Provider staff and the parent/Legal Guardian meet with the Planning Team (previously called the State MATCH Committee) to develop a Community Care Plan, which must be signed off by the Planning Team Chairperson. The Community Care Plan is written by the Core Services Provider staff and Parent/Legal Guardian, but must be developed in conjunction with and approved by the Planning Team as indicated by the signature of the chairperson. This Community Care Plan outlines services that the broader child-serving agencies will commit to in order to support and maintain the child in the community. If the Team recommends RBWO, then a service plan for during and after placement must be developed so that all parties are clear on what community supports are in place when the child returns home.
5. Intensive community services must continue to be provided by the Core Service Provider while the child awaits the disposition of the application for RBWO.
6. The completed application package, including the Inter-agency Care Community Care Plan, is submitted to the Regional C&A Program Specialist.
7. The Program Specialist reviews the application within 7 business days and ensures that all community services have been explored and exhausted. If the package is not complete, the Program Specialist will contact the Core Service Provider. Upon receipt of a complete application package, the Program Specialist will enter child information and case data into the KIDSTAR data system

8. If the Program Specialist recommends Room Board and Watchful oversight, the package will be sent to the DMHDDAD State Authorization Team for review and a determination regarding authorization will be made in cooperation with the DFCS Provider Relations Unit within 7 business days. The DMHDDAD State Authorization Team will inform the Regional Specialist and the Core Provider regarding the determination or disposition.
  
9. If authorized, the DMHDDAD State Authorization Team, along with the DFCS Provider Relations Unit, will determine the appropriate facility based on geographic proximity to the family, specialty of the Provider, and bed availability, and the DMHDDAD State Authorization Team will notify the RBWO provider, the Core Services Provider, the Regional Program Specialist, and DFCS.
  
10. When the youth is admitted to the facility, the RBWO Provider will enter the youth's admission data into the KIDSTAR data system.
  
11. DMHDDAD will conduct monthly individual utilization reviews minimally at the facility, and will review with program staff, Core Services Provider staff, Parents/Legal Guardians, and youth in order to approve continued stay, or to recommend discharge.

**REFERRAL AND ADMISSION PROCESS**  
**For Youth in Parental Custody and are not Members of a**  
**Management Organization (CMO)**  
**PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF)**

**Psychiatric Residential Treatment Facility (PRTF)** is a non-hospital facility with a provider agreement with the Department of Community Health to provide the inpatient mental health and substance abuse services benefit to eligible individuals 21 years of age or younger. The Psychiatric Residential Treatment Facilities are Coastal Harbor, Devereux Georgia Treatment Network, Hillside, Inner Harbour, Laurel Heights, and Ramsey Youth Services of Georgia d/b/a Macon Behavioral Health.

PRTF services provide comprehensive mental health and substance abuse treatment services to children and adolescents who, due to severe emotional disturbance, are in need of quality active treatment that can only be provided in a psychiatric residential treatment facility and for whom alternative, less restrictive forms of treatment have been unsuccessful or are not medically indicated. The services must be delivered under the direction of a physician. PRTF programs are designed to offer intensive, focused treatment to promote a successful return of the child or adolescent to the community. Focus is on improvement of clients' symptoms through the use of strength-and evidence-based strategies, group and individual therapy, behavior management, medication management and monitoring as needed, and active family engagement. The program is designed around partnerships with other services providers that offer treatment and supports in the community, including community support, multi-systemic therapy, functional family therapy, and other like services. The program should encourage family participation in the treatment planning and implementation processes and timely discharge planning and aftercare. Specific outcomes of the services include the resident returning to his/her family or to another less restrictive community living situation, as soon as clinically possible and when treatment in a PRTF is no longer medically necessary.

The Referral Process:

1. The Parent/Legal Guardian identifies the child as needing an assessment for behavioral health services and may enlist other professionals to assist them in gaining access to a Core Services Provider
2. The Parent/Legal Guardian contacts the Georgia Crisis and Access Line at 1-800-715-4225 or uses the website, [www.mygcal.com](http://www.mygcal.com), for a referral and appointment for an assessment at a Core Services Provider agency, or they may contact the Core Services Provider of their choice directly.

3. The Core Services Provider sets an appointment within 5 days to begin the assessment process and to determine a recommendation for treatment needs. BHL or a contract provider can assist with access to psychiatric and substance abuse crisis services.
4. The Core Services Provider assesses the child's treatment needs, makes treatment recommendations, develops an individual treatment/resiliency plan, completes the CAFAS, and submits a MICP to APS Healthcare. The treatment options or support services that the Core Services Provider may recommend are the following:
  - Core Services
  - Intensive Family Intervention (IFI) Services
  - Crisis Stabilization
  - PRTF
5. The Core Services Provider serves as a clinical home and coordinates all behavioral health care services. The Core Services Provider documents this process.

**PRTF:**

6. If the Core Services Provider recommends PRTF services, the Core Services Provider faxes the APS PRTF Admission Review Form and current psychiatric evaluation and psychological evaluation, and/or psychosexual evaluation to APS Healthcare at 1-800-728-6524.
7. If APS Care Manager determines additional information is needed, a contact to the Core Services Provider will be made within 1 business day of the referral.
8. Once telephonic review is completed, APS reviews the case with its independent team which includes a Psychiatrist/CNS and makes an admission determination within 7 days. Intensive service delivery must continue through the Core Services Provider while the child/family awaits disposition of the PRTF request.
9. If PRTF is authorized, APS informs Core Services Provider and Regional C&A Program Specialist.
- 9b. If PRTF is not authorized, APS renegotiates service request with the Core Services Provider and recommends appropriate community services. The Core Services Provider is responsible for providing and/or referring the child and family to appropriate community services. The Core Services Provider's recommendation(s) may include:
  - Core Services
  - Intensive Family Intervention
  - Crisis Stabilization Services

10. The Core Services Provider notifies Parent/Legal Guardian of the PRTF authorization, assists Parent/Legal Guardian with the selection of a facility based on geographical proximity to the family and bed availability, and participates in the admission of the child to the facility. Parent/Legal Guardian nor the Core Services Provider may place a child in a PRTF without APS authorization.
11. The PRTF must confirm with the referring Core Services Provider that authorization has been granted by APS.
12. PRTF must ensure authorization has been issued by completing the admission form and entering it into the temporary APS database.
13. APS informs ACS of the child's PRTF provider, authorization/admission and continuing stay review date.
14. Once processed, APS transmits PA information to ACS and to the PRTF provider with the PA# for billing.
15. Parent/Legal Guardian must be involved with the PRTF for discharge planning at admission and for continued stay reviews.
16. In addition to work completed in Item #15 (above), prior to the discharge, the PRTF notifies the Core Services Provider.

## **PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) REFERRAL AND ADMISSION PROCESS FOR YOUTH IN DFCS CUSTODY**

**Psychiatric Residential Treatment Facility (PRTF)** is a non-hospital facility with a provider agreement with the Department of Community Health to provide the inpatient mental health and substance abuse services benefit to eligible individuals 21 years of age or younger. The Psychiatric Residential Treatment Facilities are Coastal Harbor, Devereux Georgia Treatment Network, Hillside, Inner Harbour, Laurel Heights, and Ramsey Youth Services of Georgia d/b/a Macon Behavioral Health.

PRTF services provide comprehensive mental health and substance abuse treatment services to children and adolescents who, due to severe emotional disturbance, are in need of quality active treatment that can only be provided in a psychiatric residential treatment facility and for whom alternative, less restrictive forms of treatment have been unsuccessful or are not medically indicated. The services must be delivered under the direction of a physician. PRTF programs are designed to offer intensive, focused treatment to promote a successful return of the child or adolescent to the community. Focus is on improvement of clients' symptoms through the use of strength-and evidence-based strategies, group and individual therapy, behavior management, medication management and monitoring as needed, and active family engagement. The program is designed around partnerships with other services providers that offer treatment and supports in the community, including community support, multi-systemic therapy, functional family therapy, and other like services. The program should encourage family participation in the treatment planning and implementation processes and timely discharge planning and aftercare. Specific outcomes of the services include the resident returning to his/her family or to another less restrictive community living situation, as soon as clinically possible and when treatment in a PRTF is no longer medically necessary.

### **The Referral Process:**

1. The DFCS identifies the child as needing an assessment for behavioral health services and may enlist other professionals to assist them in gaining access to a Core Services Provider
2. The DFCS contacts the Georgia Crisis and Access Line at 1-800-715-4225 or uses the website, [www.mygcal.com](http://www.mygcal.com), for a referral and appointment for an assessment at a Core Services Provider agency, or they may contact the Core Services Provider of their choice directly.

3. The Core Services Provider sets an appointment within 5 days to begin the assessment process and to determine a recommendation for treatment needs. BHL or a contract provider can assist with access to psychiatric and substance abuse crisis services.
4. The Core Services Provider assesses the child's treatment needs, makes treatment recommendations, develops an individual treatment/resiliency plan, completes the CAFAS, and submits a MICP to APS Healthcare. The treatment options or support services that the Core Services Provider may recommend are the following:
  - Core Services
  - Intensive Family Intervention (IFI) Services
  - Crisis Stabilization Services
  - PRTF
5. The Core Services Provider serves as a clinical home and coordinates all behavioral health care services. The Core Services Provider documents this process.

**PRTF:**

6. If the Core Services Provider recommends PRTF services, the Core Services Provider faxes the APS PRTF Admission Review Form and current psychiatric evaluation and psychological evaluation, and/or psychosexual evaluation to APS Healthcare at 1-800-728-6524.
7. If APS Care Manager determines additional information is needed, a contact to the Core Services Provider will be made within 1 business day of the referral.
8. Once telephonic review is completed, APS reviews the case with its independent team which includes a Psychiatrist/CNS and makes an admission determination within 7 days. Intensive service delivery must continue through the Core Services Provider while the child awaits disposition of the PRTF request.
9. If PRTF is authorized, APS informs Core Services Provider and Regional C&A Program Specialist.
- 9b. If PRTF is not authorized, APS renegotiates service request with the Core Services Provider and recommends appropriate community services. The Core Services Provider is responsible for providing and/or referring the child and family to appropriate community services. The Core Services Provider's recommendation(s) may include:
  - Core Services
  - Intensive Family Intervention
  - Crisis Stabilization Services

10. The Core Services Provider notifies DFCS of the PRTF authorization, assists DFCS with the selection of a facility based on geographical proximity to the DFCS case manager/office and bed availability, and participates in the admission of the child to the facility. DFCS nor the Core Services Provider may place a child in a PRTF without APS authorization.
11. The PRTF must confirm with the referring Core Services Provider that authorization has been granted by APS.
12. PRTF must ensure authorization has been issued by completing the admission form and entering it into the temporary APS database.
13. APS informs ACS of the child's PRTF provider, authorization/admission and continuing stay review date.
14. Once processed, APS transmits PA information to ACS and to the PRTF provider with the PA# for billing.
15. DFCS must be involved with the PRTF for discharge planning at admission and for continued stay reviews.



<b>1.16 Admission Diagnosis:</b>		
Axis I Diagnosis (Primary) [ ] [ ] [ ] . [ ] [ ]	Axis II Diagnosis (1) [ ] [ ] [ ] . [ ] [ ]	Axis III Diagnosis (2) [ ] [ ] [ ] . [ ] [ ]
Axis I Diagnosis (Secondary) [ ] [ ] [ ] . [ ] [ ]	Axis II Diagnosis (2) [ ] [ ] [ ] . [ ] [ ]	IQ Score [ ] [ ] [ ]
Axis I Diagnosis (Tertiary) [ ] [ ] [ ] . [ ] [ ]	Axis III Diagnosis (1) [ ] [ ] [ ] . [ ] [ ]	M-GAF [ ] [ ]

**1.17 Risk Symptoms & Behaviors necessitating placement into a Psychiatric Residential Treatment Facility (PRTF)**

Clinical Status

- |     |   |                              |                             |
|-----|---|------------------------------|-----------------------------|
| 1.  | Does the consumer require residential treatment due to behavioral, emotional and family problems that cannot be addressed safely/adequately in the community/home?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2.  | Does the consumer require intensive, psychiatric treatment to decrease risk factors such as suicidal/homicidal ideation and/or aggressive behavior?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3.  | Is the consumer unable to return home or to a temporary residence at night due to psychiatric symptoms?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4.  | For at least the past 6 months, has the consumer been served at lower levels of care to address behavior and/or psychiatric symptoms with little/no success, or are those levels of care considered inappropriate due to behavioral health risks? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5.  | Is there evidence of significant family dysfunction or social relationship problems due to consumer's behavior and or psychiatric symptoms?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6.  | Is there a family history of mental illness and/or substance abuse?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7.  | Is the family/caregiver willing to engage and participate in treatment as partners in the consumer's care?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 8.  | Is the consumer eligible to return to their current home or community placement once they are appropriate to discharge from this LOC?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 9.  | Is there a pattern of significant disruptive behavior, related to a diagnosed behavioral health disorder, negatively affecting functioning in school, community, or family lasting at least the previous 6 months?                                | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 10. | Has the family/caregiver been informed and agreed to participate fully in family therapy sessions as deemed necessary and appropriate?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 11. | Does the consumer have a history of sexual offense?   | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 12. | Has the consumer been victimized? <i>(please check all that apply)</i>  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
|     | <input type="checkbox"/> neglect <input type="checkbox"/> physical abuse <input type="checkbox"/> sexual abuse  |                              |                             |
| 13. | Does the consumer have a substance abuse/dependence issue?  | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

**Admission Criteria Narrative** *(Please give additional details explaining the symptoms and circumstances which preclude a less restrictive level of care and necessitate the PRTF level of care.)*

**1.18 Safety Concerns**

Has a safety plan been developed to ensure the consumer's safe transition from a residential placement back to your agency and the community following discharge?  
*(A safety plan must be in place prior to admission to the PRTF)*

Yes       No

Safety concerns are related to which support deficit? *(Check all that apply)*

Natural supports       Behavioral supports       Medical Supports       School Supports       Living Supports

**1.19 Number of Out-of-Home Placements prior to current admission** *(Please check one)*

0-3       3-6       6-10       More than 10

**1.20 Current Symptoms and Severity (within past 24 hours)**

Indicate all symptoms/behaviors exhibited within the past 48 hours and their level of severity, with one being mild and infrequent and 5 being the most severe and frequent. (see examples in Field Definitions document). All fields must be completed, if the symptom does not apply to this consumer select NA.

Aggressive Behavior	NA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>	Obsessive/Compulsive	NA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>
Conduct Problems	NA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>	Depressed	NA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>
Oppositional Behavior	NA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>	Manic	NA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>
Suicidal Risk	NA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>	Poor Hygiene	NA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>
Homicidal Risk	NA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>	Enuresis/Encopretic	NA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>
Self Injurious Behavior	NA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>	Sleep Disturbance	NA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>
Sexual Acting Out	NA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>	Appetite Disturbance	NA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>
Distorted Thinking	NA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>	Weight Gain/Loss	NA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>
Hallucinations	NA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>	Social Withdrawal	NA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>
Anxious	NA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>	SA cravings/fixations	NA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>
Impulsivity	NA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>	Elopement Attempts	NA <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>

**Symptoms Narrative** (please give more detail on all symptoms above that are ≥ 3)

**1.21 What other community behavioral health services have been attempted in the previous six months? (Check all that apply)**

Type of Service	Frequency (Approximate)	Please indicate the consumer's level of progress and engagement in the services utilized. 1= None, 2= Minimal, 3=Moderate, 4= Significant	
		Progress	Engagement
<input type="checkbox"/> MH Day Treatment	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> PRN	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
<input type="checkbox"/> SA Day Treatment	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> PRN	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
<input type="checkbox"/> IFI/MST	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> PRN	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
<input type="checkbox"/> CST	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> PRN	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> PRN	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
<input type="checkbox"/> Individual Therapy	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> PRN	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> PRN	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
<input type="checkbox"/> Crisis Intervention	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> PRN	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
<input type="checkbox"/> CSI	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> PRN	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
<input type="checkbox"/> Medication Administration	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> PRN	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
<input type="checkbox"/> Activity Therapy	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> PRN	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
<input type="checkbox"/> Consumer/Family Assistance	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> PRN	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
<input type="checkbox"/> Crisis Stabilization	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> PRN	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
<input type="checkbox"/> Residential Supports (I, II, Other)	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> PRN	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
<input type="checkbox"/> Respite	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> PRN	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
<input type="checkbox"/> Other/List: _____	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> PRN	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
<input type="checkbox"/> Other/List: _____	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> PRN	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>
<input type="checkbox"/> Other/List: _____	<input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> PRN	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>	1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>

**Previous Treatment Narrative** (please give additional details regarding the reasons previous treatment has not been effective)