

CONTINUED STAY

Acute Care or Psychiatric Residential Treatment Facility (PRTF)
Psychiatric Services

Required Documentation: Treatment Plan Completed Continued Stay Form

Authorization DOES NOT guarantee payment or client eligibility

Date Requested:

Admission Date:

Facility:

Facility UR rep:

Phone # :

Fax #:

For APS Healthcare Use Only

Date Received:

Approved: Approved YTD: Denied: Certified Through/LCD: Reviewed By: PCN :

The facility has agreed to share the status of the authorization with the member.

In order to avoid any gaps in covered days, the CSR MUST be received on the last covered day.

Primary Physician's Name:

Address:

Contact #:

Was this admission court ordered: Y N

Current Guardian name and phone #:

Therapist name and phone#:

Parent current phone#:

PATIENT INFORMATION

Name:

Medicaid ID #:

DOB:

Current DSM IV code(s) (provide ALL code numbers as well as diagnosis names; include any changes)

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

What is the clinical rationale for continued stay at the current level of care since the last review?

Interdisciplinary Treatment Plan

1. **List of problems related to the reason for admission:**

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-
-
-
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2. **List of treatment modalities to address identified problems – Include progress and/or difficulties observed in Group Therapy, School, and Milieu summary:**

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-
-

3. **Provide a description of the measurable treatment objectives expected within the next review interval, which will indicate progress in achieving discharge goals:**

4. **Provide a description of any special therapeutic assistance, if required to help the patient achieve treatment objectives:**

5. **Provide an update on the treatment objectives which have been achieved at this point in treatment and the discharge goals remaining to be achieved at this level of care:**

6. **Provide a description of any incidents of time outs, seclusion, restraints, aggression, etc.:**

7. **Individual Therapy:** Please indicate dates, frequency, and summary of individual therapy:

8. **Family therapy (PRTF only)**: Please include names of those participating, goals, dates of each session and how it supports the discharge plan. (Family therapy must be at least one full hour per week):

9. **Onsite visits (PRTF only)**: Please include names of family participating in onsite visit, dates onsite is to occur, mode of transportation (if known). Family is aware that participation in family therapy must occur daily while onsite to avoid jeopardizing travel reimbursement.

10. **Therapeutic passes (PRTF only)**: Please indicate all date's the patient was out of the facility overnight and note whether your bed rate was over 90% for those dates:

11. **Medications** (dosages & frequency; for Psych PRN meds, specify reason and how often used, include any meds started or discontinued with dates and reason for change):

- | | |
|----|-----|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

12. **Discharge Planning**: documentation must include progress towards discharge plan including anticipated place of discharge, active planning in identifying wrap around services, and estimated discharge date. Is patient eligible for the Children's Mental Health Waiver services?

13. **Actual Discharge plan**: Include date, mode of transportation, provider names for medication management, specialized therapy aftercare, individual therapy dates, name and phone number of therapist. If the patient is being transferred to a lower level of care, what is the reason and name of the facility the patient being is being transitioned to?

14. **Estimated length of stay**:

Fax completed form to APS Healthcare toll-free @ 1- 888- 245-1928

Forms can be found on-line at www.wyhealthytogether.com