



**NARBHA Level I Residential Treatment Center Admission and Continued Stay
Authorization Request Form
PM Form 3.14.6**

Instructions: Please fax to NARBHA UM (928) 214-1166. It is necessary to submit the following documents: Admission: Treatment plan with discharge criteria and plan CFT progress note. Psychiatric Evaluation **Continued stay:** Updated treatment plan if modified. CFT 30 day review note. RTC monthly progress report. All forms must be submitted to prevent delay in authorization.

Member Name:	Member ID:
AHCCCS ID:	Responsible Agency:
Proposed or Current Facility Name:	Days Requested:
Date of Admission:	Estimated Length of Stay (days):
Requestor:	Requestor phone/pager #:
Name of physician to contact for more information:	MD phone/pager #:

I. DIAGNOSIS: Axis I: Axis II: Axis III:

II. Behavior and Functioning (must meet all)

Symptoms or functional impairments of the individual's psychiatric condition are of a severe and persistent nature; **AND**

are consistent with a DSM IV-TR diagnosis (within the range of 290 through 316.99); and

require residential 24-hour psychiatric treatment under the direction of a psychiatrist.

Must give explanation of behaviors and symptoms:

III. In addition, all of the following must be met to ensure appropriate, cost-effective and least restrictive care in this setting:

Ambulatory care resources (outpatient medically necessary behavioral health services) in the community do not meet the treatment needs of the child/adolescent; and

The child/adolescent does not require a level of medical or professional supervision that surpasses that which is available at a Level I Residential Treatment Center. (For example, children/adolescents actively showing signs of danger to self or danger to others may require inpatient psychiatric treatment at an acute psychiatric hospital); and

The **admission/continued stay** is **not** used primarily, and in a clinically inappropriate manner, as: an alternative to incarceration, preventative detention, or as a means to ensure community safety in a child/adolescent exhibiting primarily delinquent/antisocial behavior; or the equivalent of safe housing, permanency placement, or an alternative to parents'/guardian's or other agency's capacity to provide for the child or adolescent; or an intervention when other less restrictive alternatives are available and not being utilized.

Must explain why a lower level does not meet the member's needs:

IV. EXPECTED IMPROVEMENT DUE TO ACTIVE TREATMENT

Admission

Active treatment with the services available at this level of care can reasonably be expected to improve the child/adolescent's psychiatric condition in order to achieve discharge from the psychiatric residential treatment facility at the earliest possible time and facilitate his/her return to outpatient care and/or family living.



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Member Name:

Continued Stay

The Child/Adolescent is receiving services which are improving his/her psychiatric conditions in order to achieve discharge from residential status at the earliest possible time and facilitate his/her return to outpatient care and/or family living. The professional developed and supervised individual service plan has been changed (revised) if necessary to respond to any identified lack of progress. * Must submit updated treatment plan with request.

V. There is a Discharge Plan with specific discharge criteria and recommendations for aftercare treatment that comply with current standards for medically necessary covered services, cost effectiveness, and least restrictive environment: **(Please attach treatment plan with discharge criteria and plan.**

Please Explain Discharge Plan:

Provider Signature: _____ **Date:** _____