

Checklist of Supporting Materials for Pre-admission Certification Committee Review

CHECKLIST OF SUPPORTING MATERIALS: In order to prevent delay in processing this application, please fill out the identifying data completely and submit all the required information. *(All materials listed below are required to determine RTF eligibility and Medicaid disability). According to the region of the PACC, please submit the following number of collated copies: WESTERN REGION, 5 collated copies (1 contains original consents, 4 copies) & SPOA COVER & NARRATIVE*

1. COVER "ACCESSING A RESIDENTIAL TREATMENT FACILITY via SPOA"

2. CONSENTS / RELEASE FORMS FOR:

- Application for an RTF review by PACC
- Release of information signed by parent/guardian or where appropriate, the child/youth which give the PACC permission to refer to and release information to RTF providers
- disability determination
- release of info to the committee on special education
- COPY OF BIRTH CERTIFICATE, HEALTH INS. CARD(S) (Back & Front)

3. REFERRAL SUMMARY: Attached is a brief summary of the most salient features of the case, including examples and descriptions of behaviors that typify the youth's response to current placement. Include current information regarding performance of age-appropriate activities, interests, self-care skills, ability to relate to others, and certification by a mental health professional who is familiar with the case that the materials attached accurately reflect the youth's current level of functioning. In summary, why RTF level of care will serve the needs of the child.

4. PSYCHIATRIC SUMMARY: Attached is a copy of the most recent psychiatric examination (Date: _____) which includes a current mental status, history of prior psychiatric care and treatment, diagnostic formulation (with clear examples that substantiate clinical tenets), DSM IV/N diagnosis, prognosis, and a brief summary of past and present psychotropic medication and its effectiveness. *A full psychiatric examination must have been performed within the last year, with an update within the past 90 days of the time of referral, verifying that the psychiatric examination accurately reflects the youth's current level of functioning. The update must be completed by the treating MD. – PACC may request an updated psychiatric under 90 days based upon the youth's current clinical status.*

5. PSYCHOLOGICAL SUMMARY: Attached is a copy of the most recent psychological assessment (Date: _____) which includes an assessment of sensory-motor functioning, mental status, prior history of psychological problems, behavioral skills and deficits, language cognition, self-help skills, social-affective functioning, intellectual functioning (including IQ), and prognosis. Where available, an assessment of psychodynamic functioning including tentative etiology and response to prior treatment efforts is attached. Where appropriate, clear descriptive examples that substantiate clinical tenets should be provided. *The psychological examination should accurately reflect the youth's current level of functioning. The full psychological examination should be signed by a licensed psychologist and performed within the past 2 – 3 years.*

6. PSYCHO-SOCIAL which also includes the following:

a) DEVELOPMENTAL HISTORY: Attached is an assessment of the youth's developmental history which includes, where available and appropriate, an assessment of pre-, peri-, and post-natal periods, developmental milestones and problems, and problems and experiences which have interfered or may interfere with future development, peer relationships, and/or activities

b) ENVIRONMENTAL/FAMILY/SOCIAL STATUS: Attached is an assessment of family and community relationships, and where appropriate and available, characteristics of interactions with peer groups and adults, socioeconomic status, constellation of family group, emotional and health factors of the family, religious, and ethnic affiliation, current and past family problems, family's expectations and predicted involvement in treatment. *(An assessment of the family must have been performed within the last year)*

7. EDUCATIONAL/VOCATIONAL SUMMARY: Attached is an assessment of current and former school status and vocational assets/liabilities which include, where available and appropriate, intellectual or achievement test results, general classroom behavior, relationship with teachers and peers, ability to finish work, accuracy of work, use of free time, motivation, effective incentives/reinforcers *(it should be noted whether or not the applicant has been reviewed by a CSE; if so, their recommendations and at least Phase I of an IEP should be attached)*, current work skills and potential for improving or developing new skills, amenability to vocational counseling, aptitude, interests and motivation for getting involved in various job-related activities, physical abilities, skills and experience in seeking jobs. *(An Education/Vocational summary must have been performed within the last six months.)*

8. PHYSICAL STATUS: Attached is a summary and most recent assessment (Date: _____) of the youth's physical status. Materials include a statement of general overall health, general physical exam, dental and vision assessments, and where appropriate and available, a neurological exam, serology and hemoglobin reports, urinalysis, chest x-ray or tyne test report, nutritional assessment and any other physical findings. *(A physical examination must have been performed within the past year, unless there is an ongoing medical problem, in which case, within 30 days of the time of referral.)*

The following is not required for PACC review but mandatory for RTF Admission if eligible

- IMMUNIZATION RECORD
- SOCIAL SECURITY CARD (copy)

State of New York
OFFICE OF MENTAL HEALTH

Residential Treatment Facility REFERRAL MATERIAL

Applicant Information: _____ Date Received: _____

Last Name First Name Current Setting (Home, Hospital, etc)

Youth's Origination County	Date of Birth	AGE	Sex <input type="checkbox"/> M <input type="checkbox"/> F
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Is the Child an SSI Recipient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Ethnicity: <input type="checkbox"/> Black <input type="checkbox"/> Eurasian <input type="checkbox"/> Unknown <input type="checkbox"/> White <input type="checkbox"/> Native American <input type="checkbox"/> Hispanic <input type="checkbox"/> Other: _____	IQ - Full Scale	IQ Test Date	Citizenship <input type="checkbox"/> USA <input type="checkbox"/> Alien
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9 digit Social Security # (123-45-6789)	8 digit Medicaid # (AA12345A)
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Youth's Guardian(s): INCLUDE CONTACT INFORMATION FOR PARENTS & DSS OR OTHER CASEWORKER
 Parent Relative DSS OCFS Family Court Other Adopted Not Adopted

Title First Last Relationship to Child (Mom, Dad, DSS)

Street Address Telephone: (Area) 123-4567

City State ZIP County

If you checked OCFS, Family Court, or other above, please explain (restrictive placement, Juvenile Delinquent-Offender, Case Pending, etc.)

Youth's School District of Origin

School District: _____
CSE Contact: _____ CSE Phone: (Area) 123-4567

Referral Contact:
 Parent Legal Guardian Agency Self Other

Title	First	Last	AGENCY or SOURCE
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Telephone	
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Other	Address
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E-Mail Address	City	State	ZIP
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FOR OFFICE USE ONLY: _____ **Status:** _____ **COUNTY:** _____



INFORMED CONSENT FOR THE OFFICE OF MENTAL HEALTH RESIDENTIAL TREATMENT FACILITY AUTHORIZATION REVIEW PROCESS

Youth's Name (Last)	(First)	(M.I.)	Youth's Date of Birth
Youth's Address			
Referring Source Name			
Referring Source Address			

I, or my authorized representative, request that health information regarding the above-named youth's care and treatment be released as set forth on this form. In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

- A specific authorization is required to use or disclose drug or alcohol diagnoses or treatment information or confidential HIV related information.
- I have the right to know what information about the youth has been shared, and why, when, and with whom it was shared.
- I have the right to cancel my authorization to release information by notifying the referring agency or the OMH RTF Authorization Coordinator in writing, or to withdraw from the OMH RTF Authorization Review Process any time before it is released. This will stop OMH from sharing information after my consent has been withdrawn.
- I also understand that the OMH RTF Authorization Review Process may be composed of reviewers from the following agencies:
 Office of Mental Health (OMH) Office of Children and Family Services (OCFS) State Education Department (SED)
 Children-Single Point of Access (C-SPOA) Office for People with Developmental Disabilities (OPWDD)
- I authorize the release of clinical and educational information to OMH regarding the above-named youth. I understand that the OMH RTF Authorization Review Process will review and evaluate this information to determine the youth's medical necessity for authorization to apply for admission to RTF(s) and will maintain the confidentiality of this information. I understand that the information will be shared in written form, in meetings, by phone or by computerized data.
- I authorize the OMH RTF Authorization Coordinator(s) to release the above information to RTF(s). I understand that this information will be used to evaluate the youth for possible admission to the RTF(s) and that the RTF(s) will maintain the confidentiality of this information.
- Should the OMH grant authorization to apply for admission to an RTF(s) to the above-named youth, I authorize OMH to release the above information to the youth's **School District of Residence** _____ **Committee on Special Education(CSE)**, to request that the CSE evaluate the youth. I authorize OMH to then obtain the CSE evaluation and written recommendations for appropriate educational services while the youth is attending an RTF (SED Law Article 81 § 4005.1.d-e.) If the youth is in the hospital at the time of referral the school district of residence shall be the school district of residence at the time he or she entered the hospital.
- This consent to release information will expire: a) six months from the signed date if the youth is not



INFORMED CONSENT FOR THE OFFICE OF MENTAL HEALTH RESIDENTIAL TREATMENT FACILITY AUTHORIZATION REVIEW PROCESS

admitted into an RTF or b) when the youth is discharged from an RTF.

This authorization must be completed by the parent/legal guardian and youth where appropriate to use/disclose protected health information, in accordance with State and federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

NOTE WHERE INFORMATION ACCOMPANIES THIS DISCLOSURE FORM: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2 and HIPAA). The federal rules prohibit you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 and/or HIPAA. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signature of Youth (where appropriate and available)

Signature of Parent/Legal Guardian

Relationship

Print Name Signed

Date Signed

Signature of Witness

Title

Print Name Signed

Date Signed

Signature of Person Completing Form (If different from Parent/Guardian)

Title

Print Name Signed

Date Signed

FOR OMH USE ONLY

CONSENT HAS BEEN:

- Revoked in entirety
Partially revoked as follows:
Letter (Attach Copy)

DATE REQUEST RECEIVED:

OMH REPRESENTATIVE RECEIVING REQUEST:

(OMH REPRESENTATIVE'S FULL NAME AND TITLE)

REQUEST FOR DISABILITY DETERMINATION

Name of Youth: _____

Date of Birth: _____

This is to request that the Office of Mental Health (OMH) determine whether the above-named youth is disabled for the purposes of the Medical Assistance Program, as designated by the Department of Social Services.

I authorize OMH to review and evaluate any mental health, health or educational information it has received to assess whether the above-named youth is disabled. I also authorize OMH to request clarification or obtain additional documentation necessary to confirm or verify this information to determine whether he/she is disabled.

I understand that this form is not an application or reapplication for Medical Assistance benefits, and that OMH will be determining whether the above-named youth is disabled but not whether he/she is eligible for Medical Assistance.

Signature of Parent/Legal Guardian

Relationship

Date Signed

Revised 06/2020

Residential Treatment Facility/Medicaid Determination

State of New York
OFFICE OF MENTAL HEALTH

REFERRAL MATERIAL

REFERRAL SUMMARY

Referral Summary Yes No

SPOA Contacted: Yes No

Abstract

SPOA & Residential Treatment Facility

State of New York
OFFICE OF MENTAL HEALTH

REFERRAL MATERIAL

PSYCHIATRIC SUMMARY

Psychiatric Evaluation Included?

Yes

No

Includes a Multi-Axis Diagnosis & Signed by a psychiatrist!

Psychiatric Update within the past 90 days?

Yes

No

Includes an Evaluation with Multi-Diagnosis & Signed by a psychiatrist!

Primary Axis 1 Diagnosis:

Axis 1: _____

Axis 2: _____

Axis 3: _____

Axis 4: _____

Axis 5: _____

Attach Supporting Documentation

SPOA & Residential Treatment Facility

State of New York
OFFICE OF MENTAL HEALTH

REFERRAL MATERIAL

PSYCHOLOGICAL SUMMARY

Psychological Evaluation Attached: Yes No

Full Scale IQ: _____ Verbal IQ: _____
Performance IQ: _____

Psychological Evaluation Date: _____

Attach Supporting Documentation

SPOA & Residential Treatment Facility

State of New York
OFFICE OF MENTAL HEALTH

REFERRAL MATERIAL

PSYCHOSOCIAL SUMMARY

Psychosocial Summary
Including FAMILY HISTORY and DEVELOPMENTAL INFORMATION
Is Attached: Yes No

Attach Supporting Documentation

SPOA & Residential Treatment Facility

State of New York
OFFICE OF MENTAL HEALTH

REFERRAL MATERIAL

EDUCATIONAL SUMMARY

Educational Summary Attached: Yes No

Youth's Individualized Educational
Plan (IEP) is Attached: Yes No

Attach Supporting Documentation

SPOA & Residential Treatment Facility

State of New York
OFFICE OF MENTAL HEALTH

REFERRAL MATERIAL

PHYSICAL STATUS

Medical Summary Attached: Yes No

Immunization Record Attached: Yes No

Attach Supporting Documentation
