Nevada DCFS PRTF Residential Admissions Committee Referral Form v.12.13.2021

Completing and submitting this form is required so that we can review and consider your request for services. Missing/incomplete sections will cause a delay or denial. Our brochure is attached to help you understand the admission requirements and process.

Email the completed form and required attachments to DCFS-PRTF.Referrals@dcfs.nv.gov.
You may also mail the packet to PRTF Referrals, 2655 Enterprise Way, Reno, NV 89512
By completing this form, you agree that we can contact you via the means you provide us.

Referral Information

My name is (Last)_____ (First)_____ (MI) __
My phone number is _____ My email address is_____
I am associated with this youth through ☐ County/State ☐ Corrections ☐ Family/Friend ☐ Medical/Hosp ☐ Other _____
My role in relation to the youth is _____

Please consider this youth for ☐ PRTF Enterprise, Reno ☐ PRTF North, Sparks ☐ PRTF Oasis, Las Vegas

The following documents are attached: * Referral will not be staffed without current psychiatric evaluation noted below.

- ☐ **Psychiatric Evaluation : REQUIRED for Review: Current within 6 months, signed by a board-certified psychiatrist and typed or transcribed**
- ☐ Psychological Evaluation and Vineland if IQ is below 70
- ☐ Educational information including IEP if applicable
- ☐ Discharge Summaries from Inpatient treatment
- ☐ Reports from all failed placement/treatment for the last six months or more
- ☐ Most recent 90-day Reviews from all current behavioral health providers
- ☐ Existing PARs (Prior Authorization Requests) and approvals if applicable
- ☐ Child and Adolescent Service Intensity Instrument (CASII) completed within the last 90 days
- ☐ SED Determination: Who made the determination and when?

We will need immunization records, medical history, and prescription information prior to intake. Initial here_____

Demographic Information

Youth name (Last)_____ (First)_____ (MI) __
Youth preferred name if applicable_____ DOB_____ SSN_____
Does anyone need an interpreter? ☐ Y ☐ N Language_____
Gender ☐ M ☐ F ☐ O/Unknown Gender expression _____ Rooming preference_____
Physical custody (With whom does the youth live/Who is the caregiver?) ☐ County/State ☐ Biological ☐ Tribal ☐ Adoptive ☐ Other
Caregiver name (Last)_____ (First)_____ (MI) __
Caregiver address, city, state, zip_____
Caregiver phone number_____ Caregiver email address_____
Language spoken in caregiver home_____ Youth's primary language_____
What is the youth's ethnicity? ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown/Declined to Answer
What is the youth's primary race? ☐ AI/AN ☐ Asian ☐ Native Hawaii/Other Pac Islander ☐ Black ☐ White ☐ Unknown/Declined
Who is the Legally Responsible Person (LRP) who will provide the Legal Consent to Treat? LRP role in relation to the youth_____
LRP name (Last)_____ (First)_____ (MI) __
LRP address, city, state, zip_____
LRP phone number_____ LRP email address_____
LRP primary language_____ Is the youth is state custody? ☐ Y ☐ N Adopted? ☐ Y ☐ N

Diagnostic Information

Diagnosis 1 Code_____ Description_____ Narrative:
_____
Diagnosis 2 Code_____ Description_____ Narrative:
_____
Diagnosis 3 Code_____ Description_____ Narrative:
_____
Diagnosis 3 Code_____ Description_____ Narrative:
_____
Diagnosis 3 Code_____ Description_____ Narrative:
_____

Nevada DCFS PRTF Residential Admissions Committee Referral Form v.12.13.2021

Reason for referral and request for admission

Where is youth living at the time of referral? Where is youth currently receiving services? What are the reasons for requesting PRTF Services? What behaviors does the youth display that warrants placement outside the home? What behaviors place the youth or others at risk of harm?

Medications

Medication_____ Dosage/Frequency_____ Start Date_____ Prescriber_____
Medication_____ Dosage/Frequency_____ Start Date_____ Prescriber_____
Medication_____ Dosage/Frequency_____ Start Date_____ Prescriber_____
Medication_____ Dosage/Frequency_____ Start Date_____ Prescriber_____
Medication_____ Dosage/Frequency_____ Start Date_____ Prescriber_____
Is youth medication compliant? ☐ Y ☐ N Details_____

School/Education

Current school_____ Grade_____ Special Education? ☐ Y ☐ N Is there an IEP? ☐ Y ☐ N

Describe any issues related to school/education or learning

Substance Misuse

Describe youth's alcohol and substance use and history

Legal

Describe youth's involvement with the legal system. Include arrests, probation involvement, parole involvement, and other legal issues

Mental Status

Describe appearance, behavior, cooperation and reliability, speech, thought form/process/content, mood/affect, perception, cognitive functioning, and other relevant factors

Prior Inpatient Treatment

Describe prior hospitalizations and other residential treatments.

Name and Type of Facility_____ Dates of Service_____ Summary of services:

Name and Type of Facility_____ Dates of Service_____ Summary of services:

Nevada DCFS PRTF Residential Admissions Committee Referral Form v.12.13.2021

Name and Type of Facility_____ Dates of Service_____ Summary of services:

Name and Type of Facility_____ Dates of Service_____ Summary of services:

Prior Outpatient Treatment

Describe prior outpatient treatment.

Outpatient and/or in-home therapy

Name of organization_____ Dates of Service_____ Summary of services:

Psychiatric evaluation/Medication management

Name of organization_____ Dates of Service_____ Summary of services:

Coordination of care/Case management

Name of organization_____ Dates of Service_____ Summary of services:

Educational testing/Special education

Name of organization_____ Dates of Service_____ Summary of services:

Day treatment

Name of organization_____ Dates of Service_____ Summary of services:

Foster care/Group home

Name of organization_____ Dates of Service_____ Summary of services:

Crisis services/Hospital services not mentioned above

Name of organization_____ Dates of Service_____ Summary of services:

Mental health residential treatment

Name of organization_____ Dates of Service_____ Summary of services:

Alcohol or other substance misuse treatment

Name of organization_____ Dates of Service_____ Summary of services:

Juvenile probation/Parole

Name of organization_____ Dates of Service_____ Summary of services:

Child Protective Services

Name of organization_____ Dates of Service_____ Summary of services:

Wraparound In Nevada

Name of organization_____ Dates of Service_____ Summary of services:

Basic Skills Training/Psychosocial Rehabilitation

Name of organization_____ Dates of Service_____ Summary of services:

Nevada DCFS PRTF Residential Admissions Committee Referral Form v.12.13.2021

Other outpatient
Name of organization_____ Dates of Service_____ Summary of services:
_____
_____

Other outpatient
Name of organization_____ Dates of Service_____ Summary of services:
_____
_____

Rationale

In order for the youth to qualify for PRTF services, we have to demonstrate that the above inpatient and outpatient services have been unsuccessful. How have these services been unsuccessful? How have they not met this youth's needs?

_____
_____
_____
_____
_____

General Information

Who is the current case manager? ☐ N/A _____ Case Manager Organization_____

Where will the youth be placed when they complete the PRTF program? What services will need to be in place at that time?

_____
_____
_____

Who are the people who provide support for this youth? Who will be included in the Child and Family Team (CFT) meetings?

_____
_____
_____

What supports/skills has helped this youth succeed in the past? What supports/skills will help this youth be successful with their PRTF goals?

_____
_____
_____

What other organizations are you asking to consider this youth?

_____
_____
_____

What other recommendations have been made on behalf of this youth? Include the PO's and your recommendations.

_____
_____
_____

Insurance Information (Include all Prior Authorization Information in this packet)

☐ No insurance ☐ Private insurance ☐ Medicaid insurance If Medicaid, Medicaid ID#_____

If Medicaid, type of Medicaid coverage ☐ Medicaid FFS ☐ Medicaid Managed Care with _____

	Primary Insurance		**Secondary Insurance**	
Name of Insurance Company	_____		_____	
Insurance Phone Number	_____		_____	
Group # and Policy #	_____	_____	_____	_____
Policyholder	_____		_____	
Policyholder SSN and DOB	_____	_____	_____	_____
Policyholder Employer	_____		_____	
Youth relationship to insured	_____		_____	
Prescription Drug Coverage	_____		_____	

Form Completed By

Name (and credentials)_____ Date_____

Signature_____

Nevada DCFS PRTF Residential Admissions Committee Referral Form v.12.13.2021

System of Care Philosophy

We embrace the SOC Philosophy which encompasses Core Values and Guiding Principles.

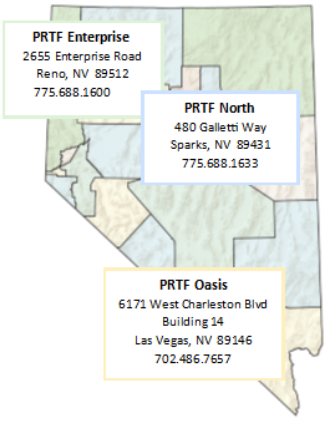
Core Values

- Community Based
- Family-driven, youth-guided
- Culturally and linguistically competent

Guiding Principles

- Broad Service Array of Effective Services and Supports
- Individualized, Wraparound Practice Approach
- Least Restrictive Setting
- Family and Youth Partnerships
- Service Coordination
- Cross-Agency Collaboration
- Services for Young Children
- Services for Youth and Young Adults in Transition to Adulthood
- Linkage with Promotion, Prevention, and Early Identification
- Accountability

The PRTFs provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socioeconomic status, geography, language, immigration status, or other characteristic



Nevada Department of Health and Human Services
DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

DCFS Psychiatric Residential Treatment Facilities

Nevada Dept of Health and Human Services
Division of Child and Family Services
Children's Mental Health

Safe, healthy and thriving kids...

http://dcfs.nv.gov/Programs/CMH/Resident-day-treatment-svcs/

What we do*

As an integral component to Nevada's System of Care continuum, Psychiatric Residential Treatment Facilities are committed to delivering evidence-informed services to Nevada youth aged 6-18 who have a severe emotional disturbance (SED).

Under Medicaid guidelines, our objective is to help youth who have behavioral, emotional, psychiatric and/or psychological disorders or conditions, who are no longer appropriate for an acute level of care, or who cannot effectively respond to services from a less restrictive setting. Youth must meet medical necessity and admission criteria.

We know that shorter lengths of stay and increased family involvement are correlated with improved outcomes (Building Bridges, 2019), and we are committed to the well being of our youth. In addition to interactive parent training, PRTF Services include room and board, active treatment, psychiatric services, psychological services, therapeutic and behavioral modification services, individual, group, family, recreation and milieu therapies, nursing services, all medications, guided family visits, case management, psychosocial rehabilitation services, and psychoeducational services under 24/7 psychiatric oversight. Educational needs may be met on or off campus, depending on the program.

Specific interventions include Aggression Replacement Training, the Boys' Town Psychoeducational Model, Cognitive Behavior Therapy, Dialectical Behavior Therapy Skills Training, and Motivational Interviewing.

Each youth is a member of their own Child and Family Team (CFT) that includes a "Primary" Behavioral Health Provider, the youth, the parents or Legally Responsible Person (LRP), and people important to the youth's well-being. The CFT meets monthly or more and collaborates to develop and implement a treatment plan, identify and overcome obstacles, and monitor progress. With coordination through Warm Handoffs, youth are typically discharged to a lower level of care within 90 days.

Residential Admissions Committee

A team of qualified mental health professionals carefully considers our residents' well-being, our staff and program capabilities, and insurance participation for each youth during our weekly Residential Admissions Committee meetings. We look for a qualifying diagnosis and parental/LRP participation. We may help you by referring you to a more appropriate provider that can meet the needs of the youth if they are affected by certain conditions, including severe psychiatric symptoms, certain sexual behaviors, chronic elopement behaviors, physical disabilities, intellectual and learning disabilities, traumatic brain injuries, pregnancy, chronic unmanageable violent behavior, medical illness, substance misuse, or diagnosis of Oppositional Defiant Disorder (ODD) or Conduct Disorder.

When you make a referral

We will ask for psychosocial information regarding the youth's:

1. Behavioral Health diagnostic and treatment history
2. School and IEP
3. Family involvement/Legally Responsible Person involvement
4. Medical and immunization history
5. Functional and behavioral history
6. Special needs or consideration

As soon as we have the information that is required, our Residential Admissions Committee will carefully review it. We will let you know if we have any questions, and we will send you a letter right away with our determination and/or recommendation.

We may then set up an intake to get some more information and signatures, then submit for an insurance authorization.

Once the authorization is issued, we can begin to plan for admission*.

**Availability may be limited depending on current census, staff capacity, and program capabilities*