# PRTF Continued Stay

Authorization DOES NOT guarantee payment or current eligibility

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| Date Requested: | | Timeline for clinical information to be submitted to Telligen:<br><br>**PRTF Continued Stay Review (CSR):**<br>The completed form must be submitted on the "end date of service" indicated in the authorization letter. Reviews submitted after this date will be subject to denied days equivalent to the number of late days.<br><br>**Required for submission:**<br>Completed Continued Stay Form<br>Treatment Plan, if updated since last review<br><br>*(if applicable, additional information requested by the Telligen care manager)* |
| Admission Date | | |
| Facility Name: | | |
| Facility NPI #: | | |
| Facility UR Rep: | | |
| Phone # | | |
| Fax # | | |
| Requested Days: | | |
| Projected DC Date: | | |

**The facility has agreed to share the status of the authorization with the client/guardian**

| PRTF Facility | |
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| Attending physician (first and last name): | |
| Physical Address: | Physician Phone #: |

| Client Information | | | |
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| Name: | DOB: | Age: | Medicaid ID#: |
| Legal Guardian's Name: | | Phone #: | |
| Parent's Name: | | Phone # | |
| Any changes in court order status of DFS involvement? | | | |
| Any changes in enrollment status in Medicaid's CME? | | | |

| Diagnoses | |
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| Code: | Diagnosis: |
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If treatment plan was not previously provided or if it was updated since the last review, attach a copy of the current treatment plan to this submission.

| List the assessments, evaluations, and/or screenings that have occurred this review period:<br>(Required documents for upload/attachment if available |
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| **Family therapy (FT) is critical to a client's success, and WY Medicaid requires a minimum of one (1) hour each week with the parent, guardian, or identified adult participant.** *When scheduled FT sessions do not occur, documented attempts to reschedule the session must be provided. When discharge disposition changes (i.e., to a relative's home), please begin to incorporate the identified caretaker in FT and note changes below. Sessions without participation from both the identified adult participant and the client, are not considered FDT sessions, unless preapproved by the Telligen CM after providing appropriate rationale.* |
| Family therapy sessions this review period. Include the date, start / stop time, name of each participant, and a brief summary of each session. In summary, include education provided to parents/caretakers regarding the client's condition and/or developing ways to support the client's progress in treatment): |

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| Describe current family issues that require stabilization, as relevant to client's success at the outpatient level. Include how these are currently being addressed in FT: |
| Document attempts to reschedule missed FT sessions: |
| List any resources, such as parenting classes, that have been recommended to parent/guardian: |

| Summary of Treatment Plan Progress | | |
|---|---|---|
| List each current treatment target | Treatment interventions being utilized to address target | Progress made toward treatment target |
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| If progress is not being made, what changes in the treatment plan will be implemented during the next review period? | | |
| If youth has been inpatient longer than 120 days, has a second opinion been initiated? | | |
| Which of the identified treatment goals could be treated in an outpatient setting? What resources and supports have been identified that need to be in place for client/family? | | |

| Onsite visits / Therapeutic Passes<br>(Ensure family is aware that participation in family therapy must occur daily while on site if seeking Medicaid travel reimbursement. Please note that Medicaid requires bed rate of 90% to bill when youth is out overnight.) | | | |
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| Onsite or pass? | Dates: | Details (who participated, outcome of pass/visit) | For onsite, did family therapy occur daily? |
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| Individual Therapy (IT) - WY Medicaid requires a minimum of one (1) hour each week.<br>*When appropriate, this hour may be broken up into shorter sessions but must equal a total of 60 minutes per week.* |
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| Individual therapy sessions this review period (include date, start/stop time, and brief summary of each session: |

| Provide brief summary updates for the current review of the following venues: |
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| Milieu: |
| Group Therapy: |
| Education: |

| Educational Information |
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| Client's Home School District: |
| Has facility been in contact with home school district? ☐ Yes ☐ No |
| If no, please describe the barriers to communication with home school district: |
| Does client have an IEP? ☐ Yes ☐ No Date IEP was last updated: |

| Medications<br>(*Medication name, dosage, frequency and date started if known; for PRN medications specify the reason and prescribed frequency; for discontinued medications include DC date.)* |
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| 1. |
| 2. |
| 3. |
| 4. |
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| 6. |

| Incidents (time outs, seclusions, restraints, aggression, etc.<br>*(Please include date, attempts to de-escalate, and plans implement to address reduction of incidents in future)* |
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| Natural Support System |
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| Describe client's natural support system including supportive family, neighbors, friends, mentors, religious community etc.: |

| Discharge Plan – A viable discharge plan is required upon admission and should be re-assessed regularly |
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| Who will the client be discharged to? |
| Please provide their contact information if it has not been provided elsewhere on this form: |
| Is it reasonable to expect the applicant could be safely served in his/her home, school and community with access to intensive, community based, behavioral health and care coordination services (including evolving crisis plans) that are individualized to the youth and family's particular needs?<br>☐ Yes ☐ No |
| If the answer above is no because the youth currently needs a higher level of care: Is it reasonable to expect this youth could be safely served in the community upon discharge, with intensive, community-based services individualized to youth and family needs in place?<br>☐ Yes ☐ No |
| Name of Physician/Psychiatrist who responded to the above 2 questions: |
| Date of response: |
| Describe the transition steps needed before the client returns home: |
| If the client is being discharged to a step-down placement, identify the placement and phone number: |
| Is there a safety plan in place? ☐ Yes ☐ No (if yes, attach a copy) |

| Waiver and CME Supports |
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| Has the parent/guardian been referred to CMHW: □ Yes □ No (application should be made 2-3 months before discharge)<br>Main office phone number: (307) 459-6162<br>Website: http://health.wyo.gov/healthcarefin/medicaid/childrens-mental-health-waiver/ |
| If applicable, has the parent/guardian been referred to the Development Disability Child Waiver?<br>□ Yes □ No (application should be made 2-3 months before discharge)<br>Main office phone number: (307) 777-7115<br>Website: http://health.wyo.gov/ddd/index.html |
| For more information on the Medicaid Care Management Entity, see the CME website:<br>http://www.magellanofwyoming.com/ For information regarding how to refer, please discuss with Telligen Care Manager |

**Submit the completed form to Telligen via the Qualitrac Portal**

**Forms can be located on line at wymedicaid.telligen.com**