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| APPLICATION FOR  CHILDREN’S RESIDENTIAL CARE FACILITY (CRCF) SERVICES\*Please submit this application electronically at [Maine ASO | Homepage (kepro.com)](https://me.kepro.com/)\* |

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| **DEMOGRAPHICS** |
| **MaineCare ID** | **First Name** | **Last Name** | **DOB** | **Age** |
|       |       |       |       |       |
| **Youth Is In Child Welfare Custody?** **Yes      No** | **Is Department of Corrections Involved? Yes     No**  |
| **Legal Guardian #1** | **Legal Guardian #2** |
| Name:       Address:       Phone:       Email Address:   | Name:       Address:       Phone:       Email Address:  |
| **Current Location:** [ ]  Home/Foster Home [ ]  Psychiatric Hospital [ ]  Emergency Department [ ] CRCF Out of State CRCF [ ]  Long Creek [ ]  Shelter [ ]  Crisis Unit [ ]  Other:      Physical address of current location:       |
| **REFERENT** |
| Name:      Agency:      Address:      :  | Phone:      Email:       | Supervisor Name: Email:       |       Phone:       |
| Referent relationship to youth: Choose an item. If Other is chosen, please explain:      \*The youth’s Behavioral Health Home and/or Targeted Case Management provider should be the referent for new applications.\* |
| **Is this a lateral transfer of services request (CRCF to CRCF)?** [ ]  Yes [ ]  No **If yes, you must include a copy of the Individual Treatment Plan (ITP) and a clinical letter addressing the items below:**1. Youth’s Trauma history and current and past diagnoses.
2. Initial presentation and need at admission to the agency.
3. Youth and Family Therapy Goals and progress since admission.
4. A description of recent behaviors and symptoms that have required the need for this youth to transfer to include the frequency, intensity and duration of the behaviors and symptoms and the strategies and attempts made by the agency to provide treatment.
5. Please provide an explanation of why the youth can no longer be served by the agency and include specific components that will need to be in place at the receiving CRCF to successfully treat this youth.
6. Specific plan to ensure a trauma-informed transition for the youth.

 **For transfers, please do not fill out the rest of this application.** |
| **Is the member currently in a correctional facility?**  [ ]  Yes [ ]  No**If yes, in addition to clinical information from the facility, please provide the clinical documentation for the 2 months prior to the youth entering the facility.** |
| **A Children’s Behavioral Health Program Coordinator (BHPC) must be consulted prior to submission of the application. The consultation form provided by the BHPC after consultation is required as part of the application for CRCF. Consultation with a BHPC is not an approval for CRCF Services.**Name of BHPC consulted:      Is consultation form attached? YES    NO  |
| **The Parent Acknowledgement Form is required to be reviewed with the guardian, signed and uploaded with the CRCF Services application. Has the Parent Acknowledgement Form been completed?**[ ]  No[ ]  Yes  |
| **Please list team members, other than the youth and guardian, who will participate in the eligibility assessment that is part of the CRCF application process. Please include all team members that can provide relevant information related to the youth’s behaviors and clinical needs. This may include treatment providers, family supports and others with knowledge of the youth.****Name:**     **Relationship to youth**:     **Email**:     **Phone**:    **Name:**     **Relationship to youth**:     **Email**:     **Phone**:    **Name:**     **Relationship to youth**:     **Email**:     **Phone**:    **Name:**     **Relationship to youth**:     **Email**:     **Phone**:    **Name:**     **Relationship to youth**:     **Email**:     **Phone**:     |
| **EDUCATION** |
| Most Recent School Attended:      Does the youth have an Individual Education Plan (IEP)? YES     NO     **OR** A 504 Plan? YES    NO    If yes, what is the area of disability noted in the IEP/504 plan?       |
| **MEDICATIONS** |
| **Is the child presently taking medications to address a Mental Health Diagnosis?**[ ] No If medications are indicated and not accessed, please provide explanation:      [ ] Yes Name and date of document with current medications (list and attach):        |
| **ELIGIBILITY CRITERIA**  |
| **Diagnoses given within the past 6 months**           Please list the title and date of document(s) that support this criterion (list and attach)[ ] :      Please enter Full Scale IQ (Required for Youth With Intellectual Disabilities)    Date Given:Click or tap to enter a date.    Provider:     |
|  **Member displays behavioral abnormalities to support level of care documented by behavioral and/or medical professionals that have recently provided treatment to the child and/or family.**[ ]  No[ ]  Yes Please list the title and date of document(s) that support these criteria (list and attach)[ ] :       |
| **Member displays failure to establish or maintain developmentally appropriate relationships with adult caregivers or authority figures.**[ ]  No [ ]  Yes Please list the title and date of document(s) that support these criteria (list and attach)[ ] :       |
| **Member displays failure to demonstrate or maintain developmentally appropriate peer relationships.**[ ]  No[ ]  Yes Please list the title and date of document(s) that support these criteria (list and attach)[ ] :       |
| **Member displays failure to demonstrate a developmentally appropriate range and expression of emotion or mood.** [ ]  No[ ]  Yes Please list the title and date of document(s) that support these criteria (list and attach)[ ] :       |
| **Member displays disruptive behavior sufficient to lead to isolation in or from school, home, therapeutic, or recreation settings.**[ ]  No[ ]  Yes Please list the title and date of document(s) that support these criteria (list and attach)[ ] :       |
| **Member displays behavior that is seriously detrimental to the youth’s growth, development, safety, or welfare, or to the safety or welfare of others; or behavior resulting in substantial documented disruption to the family including, but not limited to, adverse impact on the ability of family members to secure or maintain gainful employment.**[ ]  No[ ]  Yes Please list the title and date of document(s) that support these criteria (list and attach)[ ] :       |
| **Member’s functioning has not significantly improved using outpatient or home and community-based treatment models over the prior two (2) to six (6) months as evidenced by one (1) or more of the following:*** 1. **The member cannot be safely maintained at home or in the community due to documented risk of harm to self and/or others; or**
	2. **The member demonstrates persistent, serious, disruptive and/or defiant behavior, aggression, and/or impulsivity related to their diagnosis and this behavior is observed and documented to negatively impact the member’s functioning in at least two (2) of the following settings: home, school/work, and/or community; or**
	3. **The member demonstrates chronic truancy, is at increased risk for expulsion, suspension, and/or is involved with the juvenile justice system.**

[ ]  No[ ]  Yes Please list the title and date of document(s) that support these criteria (list and attach)[ ] :       |
| **If the member is in need of ID/DD CRCF Services, the member must be assessed with the most current version of the Vineland Adaptive Behavior Scale or the Adaptive Behavioral Assessment Scale within the past 6 months. Is this document attached?**[ ]  No[ ]  Yes  |
| **A physician or primary care provider must also document in writing, within the last 60 days, this model of service is medically necessary for the member. Is the letter of medical necessity attached?** [ ]  No[ ]  Yes |
| **Date of Application:**       |

**KEPRO**

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

**Member Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ SSN: \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize

(name and address)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(name and address of organization and/or person making disclosure)

to disclose to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and

(name and address of organization and/or person receiving information)

authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(name and address of organization and/or person disclosing or re-disclosing information)

to disclose to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(name and address of organization and/or person receiving disclosed or re-disclosed information)

**The following information:**

\_\_\_\_ Medical history, examination reports, \_\_\_\_ Laboratory reports \_\_\_\_ Reports of participation and progress and treatment

 and medications \_\_\_\_ Prescriptions \_\_\_\_ Discharge plans

\_\_\_\_ Operation reports \_\_\_\_ Consultations \_\_\_\_ Treatment or tests

\_\_\_\_ X-ray reports \_\_\_\_ Diagnosis \_\_\_\_ Copies of all other reports

\_\_\_\_ HIV test results \_\_\_\_ Results of drug screens \_\_\_\_ Mental health records, psychiatric, social,

\_\_\_\_ Fitness for duty concerns \_\_\_\_ Job performance functions psychological, and other allied health evaluations

\_\_\_\_ Alcohol, drug abuse reports \_\_\_\_ Hospital records, reports, dates of hospitalization and discharge

\_\_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose(s) or need(s) for release:**

\_\_\_\_ Ongoing diagnosis, treatment planning, social, vocational, fiscal or educational planning

\_\_\_\_ Determining the appropriateness of services being provided and coordination of diagnostic evaluation, treatment planning and/or medical, social, vocational and/or psychological service delivery

\_\_\_\_ Rehabilitation case management of medical condition as a result of a workers' compensation injury

\_\_\_\_ Claims appeal or claims processing

\_\_\_\_ For any lawful purpose

\_\_\_\_ Other

**This authorization includes the types of information set forth above generated until the date of signature AND subsequently if generated before: (Provide date): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

I understand that individually identified health information (“IIHI”) is protected under Federal and/or State confidentiality law. I further acknowledge that the information to be released was fully explained to me and this authorization is given of my own free will. I may withdraw this authorization to disclose IIHI at any time by written revocation except to the extent that the program or person that is to make this disclosure has acted in reliance on it. Upon revocation of this authorization, further release of IIHI authorized by this shall cease immediately. If not previously revoked, this authorization will terminate upon \_\_\_ year(s) from the date written on this form. A file copy is considered equivalent to the original.

**I understand that if the organization authorized to receive the information is not a health plan or health care provider, or a contractor thereof, the released IIHI may no longer be protected by federal privacy regulations. I understand that my health care and payment for my health care will not be affected if I do not sign this form. I understand that KEPRO will [not] receive financial or in-kind compensation in exchange for using or disclosing the IIHI described above.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent, Guardian or Authorized Representative, Date

(if required, and relationship)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Child Welfare Guardian if in State Custody Date

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient is: \_\_\_ Minor \_\_\_\_ Incompetent \_\_\_\_Deceased

Legal Authority: \_\_\_ Parent or Legal Guardian \_\_\_\_Next of Kin of Deceased

**The person signing this authorization is entitled to a copy.**

**TO THE RECIPIENT OF CONFIDENTIAL INFORMATION: PROHIBITION ON REDISCLOSURE.** If the information disclosed to you relates to alcohol and other substance abuse treatment, this information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any 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. 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 prosecue any alcohol or other substance abuse patient.