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 to: Sara Strack, MHC RTF Specialist, NYSOMH Western NY FO, 737 Delaware Ave., Suite 200, Buffalo, NY 14209**

☐ **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 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/V 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)

Final: 07/19/2019

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 Originating County:

Date of Birth

AGE ?

Sex
O M
O F

Is the Child an SSI Recipient?
O Yes O No

Ethnicity:
☐ Black ☐ Eurasian ☐ Unknown
☐ White ☐ Native American
☐ Hispanic ☐ Other

IQ - Full Scale

IQ Test Date

Citizenship
O USA
O Alien

9 digit Social Security # (123-45-6789)

8 digit Medicaid # (AA12345A)

Youth's Guardian (s): INCLUDE CONTACT INFORMATION FOR PARENTS & DSS OR OTHER CASEWORKER

O Parent O Relative O DSS O OCFS O Family Court O Other

O Adopted O Not Adopted

Title First Last Relationship to Child (Mother, Father, DSS)

Street Address

Telephone: (Area) 123-4567

NY

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

Telephone:
other

AGENCY or SOURCE

Address

City, State, ZIP

E-Mail Address:

FOR OFFICE USE ONLY:

Status:

COUNTY:

Office of
Mental Health

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

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health

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)

Revised 06/2020

Office of
Mental Health

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

REFERRAL SUMMARY

Referral Summary ○ Yes ○ No

SPOA Contacted: ○ Yes ○ No

FOR OFFICE USE ONLY:

☐ Birth Cert. ☐ Health Ins. Card ☐ SS Card ☐ Cover ☐ Consents ☐ SPOA ☐ Referral Summary ☐ Psychiatric ☐ Psychological ☐ Psychos

Abstract:

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-Axis Diagnosis & Signed by a psychiatrist!

Primary Axis1 Diagnosis:

Axis 1

Attach Supporting Documentation:

PSYCHOLOGICAL SUMMARY

Psychological Evaluation Attached: ○ Yes ○ No

Full Scale IQ:

Verbal IQ:

Performance IQ:

Psychological Evaluation Date:

Attach Supporting Documentation:

PSYCHOSOCIAL SUMMARY

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

Attach Supporting Documentation:

EDUCATIONAL SUMMARY

Educational Summary Attached: ○ Yes ○ No

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

Attach Supporting Documentation:

PHYSICAL STATUS

Medical Summary Attached: ○ Yes ○ No

Immunization Record Attached: ○ Yes ○ No

Attach Supporting Documentation: