CHILDREN'S TREATMENT SERVICES LEVEL OF CARE (LOC) DETERMINATION CONTINUED STAY REVIEW (CSR)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CHILDREN AND FAMILY SERVICES
SFN 826 (7-2024)

Clear Fields

Directions: This form is completed by the custodian, parent, or guardian for all children placed in a Treatment Level of Care (PRTF, QRTP or TFC) for treatment. The continued stay review form must be completed no greater than 20 days prior to placement expiration and no less than 14 days before the placement approval expires. The Qualified Individual will have 7 days to review the request for the child to continue in a treatment setting. The custodian, parent, or guardian is responsible to track the placement length of stay and work with the treatment agency to ensure progress is being made.

CHILD INFORMATION

Last Name	Name (First, Middle Initial)	Date of Birth
Court Case File Number (if applicable)		

TREATMENT AGENCY INFORMATION

Current Level of Care ☐ PRTF ☐ QRTP ☐ TFC	Agency Name	
Agency Contact		Telephone Number
Email Address		
Continued Stay Review Type ☐ 3 Month ☐ 6 Month ☐ 9 Month ☐ 12 Month		
Admit Date to Current Level of Care	Total Number of Days at the Child's Current Level of Care	

INFORMATION SOURCES

Information Sources to be Interviewed as part of the assessment, including: members of the Child and Family Team (CFT), treatment providers, parent/guardian involved in the child's case.

Name of Primary Support or Child & Family Team Member	**Relationship to Child** (mother, father, sibling, grandparent, guardian ad litem, foster care provider, teacher, treatment provider, therapist, case manager, school personnel, etc.)	**Telephone Number**	**Email Address**

Involvement: Describe each primary support's involvement in the child's treatment, giving specific examples since the last review.

CHILD'S CURRENT AND CONSISTENT BEHAVIOR/SYMPTOMS This is specific to the past 90 days only. The custodian, parent or guardian must provide the recent progress notes and incident reports that support boxes checked below.

D=Daily; W=Weekly; M=Monthly

	D	W	M
Anxiety/Excessive worry	☐	☐	☐
Danger/Violence to others	☐	☐	☐
Threatening behaviors or actions	☐	☐	☐
School refusal	☐	☐	☐
School misbehavior	☐	☐	☐
Intentional misbehavior	☐	☐	☐
Impulsivity	☐	☐	☐
Self care/Hygiene	☐	☐	☐
Depression	☐	☐	☐
Property destruction	☐	☐	☐
Psychosis	☐	☐	☐

	D	W	M
Physical aggression	☐	☐	☐
Fire setting	☐	☐	☐
Harm to animals	☐	☐	☐
Harm to self	☐	☐	☐
Suicidal thoughts or statements	☐	☐	☐
Suicidal attempts	☐	☐	☐
Problems with authority/ Following rules	☐	☐	☐
Peer relationship issues	☐	☐	☐
Runaway	☐	☐	☐

	D	W	M
Panic attacks	☐	☐	☐
Sexually abusive behaviors	☐	☐	☐
Sexual exploitation	☐	☐	☐
Substance use	☐	☐	☐

☐ Other: _____

☐ Other: _____

☐ Other: _____

Detail the child's mental health diagnosis, Intellectual or Developmental Disability Diagnosis and medications.

REASON FOR CONTINUED STAY

Describe in detail the severity and intensity of the current (within the last 90 days) /consistent behaviors and symptoms which require continued treatment at this level of care?

What services, supports, interventions or planning have been needed to address the child's needs at the current treatment placement?

What service and supports would be necessary for the child to transition to a lower level of care or return home? **(Note:** Completion of treatment is not an acceptable response without specific goals identified)

Discharge planning is expected to begin at the date of admission. What is the anticipated discharge date and detailed discharge plan. If the discharge date has changed since admission, explain why and what steps have been taken towards the discharge plan?

Level of Care Being Sought
☐ PRTF ☐ QRTP ☐ TFC

Requesting approval for stay beyond the placement maximum:
☐ Yes - answer the next question ☐ No

Answer if only requesting continued stay beyond the placement maximum. *If yes, provide the narrative below:*

In order to accept the application, the referral must attach details from the past 90 days specific to:

☐ IEP, specialist assessments or evaluations not completed by the treatment agency or previously submitted to Maximus.

By typing my name below, I am signing this document electronically. I agree that my electronic signature is the legal equivalent of my manual/handwritten signature. I agree that the electronic signature appearing on this document has the same validity and enforceability as a handwritten signature.

REFERRAL INFORMATION	
Who completed the form? ☐ HSZ ☐ DJS ☐ Tribal Nation ☐ Parent/Guardian ☐ Other: _____	
Name of Referrer	Referral Date
Email Address	Telephone Number

TREATMENT AGENCY ONLY:

☐ The treatment agency must submit the attestation SFN 831 Children's Treatment Services LOC Determinations-Attestation and supporting documentation completed and obtained by the agency, including treatment plans, progress notes, therapy notes, incident reports, medication lists, diagnosis detail and psychiatric notes