



CHILDREN'S TREATMENT SERVICES
LEVEL OF CARE (LOC) DETERMINATION-ATTESTATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES
 CHILDREN AND FAMILY SERVICES
 SFN 831 (7-2024)

Clear Fields

*This document is specific for Children's Treatment Services **LOC Determinations** initial and continued stay reviews. This document is specific to children placed in a ND PRTF, QRTP or TFC levels of care and documents that shall be submitted from the treatment agency to Maximus with a copy sent to the custodian and parent or guardian as supporting documentation for the initial or continued stay review.*

Treatment Agency	Current Level of Care <input type="checkbox"/> PRTF <input type="checkbox"/> QRTP <input type="checkbox"/> TFC
Name of Child	Child's Admission Date
Name of Custodian, Parent or Guardian	Approval Expiration Date

Assessment Type (supporting documents must be submitted with this form when completed)

<input type="checkbox"/> Initial-Emergent Placement (Must submit to Assessment Pro within 48 hours of admission) Documentation Required: (check all that apply) <input type="checkbox"/> Suicide Risk Screening <input type="checkbox"/> Mental Health Screening <input type="checkbox"/> Health Screening <input type="checkbox"/> Other (describe below):	<input type="checkbox"/> Continued Stay Review (Must submit no greater than 20 days prior to expiration and no less than 14 days before approval expires.) Documentation Required: (check all that apply) <input type="checkbox"/> Treatment Plan(s) <input type="checkbox"/> Documentation of Discharge Planning <input type="checkbox"/> Assessment(s) or Specialist Evaluations <input type="checkbox"/> Individual/Group/Family Therapy Notes <input type="checkbox"/> Psychiatric Notes <input type="checkbox"/> Incident Reports <input type="checkbox"/> Behavior Logs <input type="checkbox"/> Visitation Documentation <input type="checkbox"/> Other (describe below):
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Summary of child's current symptoms and behaviors pertinent to the last 90 days that require continued treatment:

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

Treatment Agency Contact Information

Employee Name	Agency Role	Date
Telephone Number	Email Address	