Residential Treatment Center (RTC) Application

Patient's Name:	**Sponsor SSN:**
DOB: Age:	Date of Application:
Patient Address:	
City: State: Zip:	
Name of Parent/Legal Guardian:	
Telephone:	
Other Insurance: ☐ Yes* ☐ No *If yes, please specify:	
Patient's current placement: ☐ Home ☐ Other family ☐ Hospital ☐ Foster Setting ☐ Juvenile Detention	

RTC APPLICATION INSTRUCTIONS

This application must be completed, legible, and **signed** by the current treating **Physician or Clinical Psychologist** (PsyD or PhD). No other licensed clinicians can refer) who is recommending treatment in a RTC to avoid any delays. Information must be current and based on recent contact with the patient and family. Please fax this completed form with attachments to

FAX: (866) 811-4422

Note: Parent/guardian(s) may want to duplicate all of these materials since much of the same information will be required by the facility for which the applicant is being considered.

Services must be provided by a KePRO- Certified RTC for Children and Adolescents. A list of RTCs is available on the KePRO website: http://tricare.kepro.com/

RECOMMENDED DOCUMENTATION

To assist in determining medical necessity for residential treatment placement it is **strongly recommended** that the following clinical documentation be provided as available/applicable:

- Current Psychiatric Evaluation by a psychiatrist (within 30 days of the request)
- Detailed psychosocial history
- If hospitalized, include the family therapy, individual therapy and doctor's progress notes for the current stay and indication of the outpatient provider support of RTC.
- Clinical from Previous Inpatient Psychiatric admissions
- If outpatient, include a letter from each outpatient provider summarizing the intensity of treatment over the past six (6) months and why treatment is failing or a copy of the treatment records for the past eight (8) visits.

*****Failure to complete all fields and include the supporting legible documentation could result in an adverse decision. *****

DSM 5 Diagnosis:
Is there cognitive/intellectual impairment? ☐ Yes*☐ No * If yes, attach copies of psychological tests & describe:

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Are there any significant physical or medical problems? ☐ Yes* ☐ No If yes, please describe:
Describe in detail patient's current condition, including mental status and behavior symptoms, for which Residential Treatment might be necessary.
Reasons why the patient cannot be treated at a lower level of care?
What attempts have been made to treat the patient with the maximum intensity of services available at a less intensive level of care, especially within the past 6 months:

Treatment/Involvement	***Provider(s)***	***Frequency***	***Start/End Dates***	***Comments***
Individual Therapy				
Family Therapy				
Partial Hospital				
Psychiatric Medication Management				
Psychiatric Hospitalization(s) (last 3 years)				
Community Services				
Child Protective Services				
Arrests/Legal Charges				
School Services				
Military Agencies				
Case Management				

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Current Psychiatric Medications	Dose/Frequency

Past Psychiatric Medication Trials	Start/End Date	Results/Reason for Discontinuation

Substance Type	Amount/Frequency	Duration	Age Started	Last Use	Treatment	Outcome/Results

Describe patient's current family structure (living situation, parental roles, family strengths, areas needing improvement):

List goals necessary and attainable for the patient/family within a Residential Treatment setting. Treatment duration may be several months:
1.
2.
3.

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If family involvement is therapeutically contraindicated, please explain.
Are any barriers anticipated with reunification back into the family home after discharge from RTC?

Family Therapy Requirements:

- If the custodial parent resides within 250 miles of the RTC, the custodial parent/family is encouraged to participate in weekly on-site family therapy.
- If the custodial parent resides more than 250 miles from the RTC, the custodial parent/family is encouraged to participate in monthly on-site family therapy and weekly geographic distant family therapy (GDFT).

This requirement has been discussed with the custodial parent; they understand and agree to participate

YES NO

Name of local therapist proposed to participate in GDFT, if applicable:

Requested Facility:		
Estimated Length of Stay:		
Licensure type: □ MD □ DO □PsyD □ PhD **(No other licensure type accepted)**	Provider NPI #	
Provider Address:		
City:	State:	Zip:
Provider Telephone:	Provider Fax:	
Provider Point of Contact:	Telephone:	
Physician/Psychologist Certification: I certify that I am the person rendering this patient's face to face clinical services and the above statements are true and I have obtained appropriate signed release for all information provided to TRICARE South Division Behavioral Health.		
Provider Printed Name:		
Provider Signature:	Date:	

Complete all fields in this application. Indicate "N/A" for sections that are not applicable.

In order for ValueOptions® to communicate healthcare related information to anyone other than the beneficiary/patient Authorization for Release of Information (ROI) forms may be required even for minor children.

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