Application for Residential Treatment Center Placement
(Must be completed by family)

This statement serves to inform you of the purpose for collecting personal information required by TRICARE® Health Net Federal Services and how it will be used.

AUTHORITY: 10 U.S.C. Chapter 55; 38 U.S.C. Chapter 17; 32 CFR Part 199; 45 CFR Parts 160 and 164, Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules; and E.O. 9397 (SSN), as amended.

PURPOSE: To obtain information from individuals necessary for their enrollment in TRICARE Programs including managing enrollment through web-based tools, assisting individuals in obtaining authorizations, eligibility determinations, healthcare provider referrals, and customer services, and facilitating medical management, provider services, and payment activities.

ROUTINE USES: In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, these records may be specifically disclosed outside the Department of Defense as a routine use under 5 U.S.C. 552a(b)(3) as follows: to the Departments of Health and Human Services and Homeland Security, and to other Federal, State, local and foreign government agencies, private business entities under contract with the Department of Defense, and individual providers of care, on matters relating to eligibility, claims pricing and payment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation.

DISCLOSURE: Voluntary. If you choose not to provide your information, no penalty may be imposed, but absence of the requested information may result in administrative delays or the inability to process an individual's request.

DIRECTIONS: The family/legal guardian must complete this application. Residential Treatment Center (RTC) placement cannot be considered without documentation of treatment, including outpatient intensive measures (multiple weekly visits), family therapy and/or acute inpatient admissions. Health Net Federal Services, LLC (Health Net) will process the request once the physician and family packets have been fully completed and received. Incomplete or illegible documentation will result in a processing delay of this request.

Services must be provided by a KēPRO℠ certified RTC for children/adolescents. A current listing is available on the KēPRO website: http://tricare.kepro.com. Choose the "Mental Health Facilities" tab. On the right side click on the "Facility Listing Report" and choose the most recent month. This report has a listing of all certified RTCs by state.

For questions on the RTC benefit, help locating KēPRO certified facilities or assistance completing this form please contact 1-877-TRICARE (1-877-874-2273). Submit this application and all supporting documentation to 1-877-809-8667.

GENERAL INFORMATION:

Date of request:	
Patient Information	
Patient name:	Patient date of birth:
Sponsor name:	Sponsor Social Security number:
Patient address:	
Custodial Guardian Information	
Name:	
Address:	

Home telephone number:	Work telephone number:

REASON FOR REQUEST

Why are you requesting residential treatment services for this child?

What is your greatest concern about your child's behavior?

SOCIAL SITUATION

Where does the child currently reside?

Marital status of parents

Number of siblings and where do they live?

If child is at home, has his/her behavior disrupted the family environment? If so, how?

Detail evidence of substance use/abuse, risky behaviors, sexual activity and psychiatric symptoms (such as depression, agitation, anxiety, etc).

What family/social supports are available (such as friends, relatives, church, community organizations)?

Involvement of other agencies for child:

Juvenile Justice/Probation (Explain and give the name and telephone number of all involved.)

School (including date of current IEP)

Child Protective Services (Explain and give names of all involved.)

Financial Services (e.g.: Medicaid)

TREATMENT WITHIN THE LAST 12 MONTHS

Specify Type of Service: Inpatient; Partial Hospitalization; Residential Treatment Center; Outpatient Individual, Group and/or Family Therapies

Type Service	Name Provider/Facility	Approximate Dates of Service	If Outpatient:	
			Frequency	Attendees

Has your child accessed a military treatment facility (MTF) for behavioral health services? ☐Yes ☐ No
If yes, specify where, when and with whom:

Medication Management Provider

Current Medications	Dose	Reason

The TRICARE RTC benefit is for medically necessary treatment, not for long-term placement. Family participation is required and the goal of treatment is to return the child home. The residential treatment is intended for stabilization, so that treatment can resume on an outpatient basis.

- The decision of frequency and who must participate in family therapy is based upon the clinical circumstances.
- For families located within 250 miles traveling distance of the RTC, family therapy is conducted on site.
- When families are located at a distance from the RTC (250 miles or more) they are **required** to attend family therapy on site once each month. However, the family must meet with a therapist in their own community. The family's community therapist may collaborate and hold combined

telephonic sessions with the child's therapist at the RTC. This is known as Geographically Distant Family Therapy (GDFT).

- To facilitate GDFT, the community therapist is authorized as part of the RTC process. There is no copayment for the family for this service.
- It is expected GDFT begin with the first two weeks of the patient's admission to the RTC.

This Residential Treatment Center application is for:

_____

(Name of child)

I/We understand the TRICARE RTC benefit is for medically necessary treatment, not for long-term placement. I/We agree to abide by the requirements of family therapy.

_____

(Parent/guardian)

_____

(Parent/guardian)

_____

(Date)

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Application for Residential Treatment Center Placement
(Must completed by physician)

DIRECTIONS: The referring physician must complete this application. In addition, submit any **available** supporting documentation (such as reports listed on the last page) with the application. Residential treatment center (RTC) placement cannot be considered without documentation of treatment, including outpatient intensive measures (multiple weekly visits), family therapy and/or acute inpatient admissions. Health Net Federal Services, LLC (Health Net) will process the request once the physician and family packets have been fully completed and received. Incomplete or illegible documentation will result in a processing delay of this request.

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GENERAL INFORMATION

Date of request:	
Patient Information	
Name:	Patient date of birth:
Address:	
Sponsor name:	Sponsor Social Security number:
Custodial Guardian Information	
Name:	Address:
Home telephone number:	Work telephone number:
Requested RTC Facility Information	
Name:	Telephone number:

CURRENT CONDITION

DIAGNOSIS

AXIS I:
AXIS II:
AXIS III:
AXIS IV:
AXIS V/GAF:

SYMPTOMATOLOGY CHECKLIST

(As applicable to current condition)

- ☐ Chronic and persistent danger to self or others
  - ☐ Fire setting
  - ☐ Self-mutilation
  - ☐ Runaway (longer than 24 hours)
  - ☐ Daredevil/impulsive behavior
    - Specify: _____
  - ☐ Sexually inappropriate/aggressive/abusive
  - ☐ Unmanageable behaviors
    - ☐ Angry outbursts/aggression
    - ☐ Psychotic symptoms
      - Specify: _____
  - Present greater than six months: ☐ Yes ☐ No
  - Expected to persist: ☐ Yes ☐ No
- ☐ Persistent violation of court orders
- ☐ Habitual substance use
  - ☐ Anxiety with associated symptoms increasing
  - ☐ Depressed/irritable mood and associated symptoms increasing
  - ☐ Manic/hypomanic and associated symptoms increasing
  - ☐ Psychotic symptoms increasing

Description of current condition including mental status and behavioral symptoms for which residential treatment might be needed (include explanation of all behaviors checked above):

LIVING SITUATION

Barriers to being managed in the community (including why he/she cannot be managed at home and/or outpatient, etc.):

Community or military agencies involved in working with this patient or with the family (include court/legal history, social services, family advocacy, school system, etc.):

MEDICATIONS (Include all current medications):

Medication	Dosage	Frequency	Start Date

TREATMENT (Start with most recent):

Type of Service (individual, group, family, partial hospitalization, inpatient)	Name of Provider/Facility	Approximate Start/Admission Date	If outpatient, frequency of services (daily, weekly, etc.)

Patient's response to current treatment program, indicating what aspects have been effective and what aspects have been ineffective:

PHYSICIAN CERTIFICATION

This is to certify I am rendering care to this patient, the above statements are true and appropriate, signed releases for the information provided to Health Net have been obtained. It is my recommendation that this child be admitted to a residential treatment center.

Physician name:	
Physician address:	
Physician phone:	Fax:
Tax ID number:	

(Physician Signature)

(Date)

SUPPORTING DOCUMENTATION

To assist in determining necessity for residential treatment placement, please include the following clinical documentation as available/applicable:

- ☐ Family/social history
- ☐ Psychiatric/clinical evaluation (including presenting problem, diagnosis, treatment needs, prognosis)
- ☐ Current psychological evaluation (including testing)
- ☐ Educational assessment with levels of academic achievement
- ☐ Physical and neurological examination results
- ☐ Discharge summaries from previous inpatient and outpatient treatment