***Complete this form and fax to 1-888-656-2586.***

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| --- |
| Please provide all requested information below, along with all supporting documentation listed at the end of the form. Incomplete or missing information may result in a delay in decision and care. Magellan staff will review the submitted documentation and render a decision within five business days if all documentation has been received. Authorization decisions will be communicated to the individual listed as the *Referral Contact*.  |

**Date of Request:**

**Requested Date of Admission:**

Name of Person Completing Form:

Facility Name (if known):       Facility Phone Number:

Service Address, City, State, ZIP Code:

Facility Tax ID:       Facility MIS (Magellan ID#):

Facility Contact Person:

Facility Contact Phone Number:       Facility Contact Fax Number:

Attending Physician:       Attending Physician NPI:

Referral Contact:

Referral Contact Phone Number :       Referral Contact Fax Number:

Child Name:       Gender:

Child DOB:       Child Medicaid ID:

Child Address (legal guardian address/permanent address):

Child Current Residence/Placement:

Who has custody of the child (biological parents, other family, adoptive parents, IDHW, other agency)?

Custodian Address:

Custodian Name and Phone Number:

Has the child had any recent psychological testing? [ ]  Yes [ ]  No Date of Assessment:

Admitting Behavioral Health Diagnoses:

Physical Health Diagnoses:

**Reason for Residential Treatment Request** (*check all that apply and that are current or within the last 30 days*):

[ ]  Self-harming behaviors [ ]  Suicidal behaviors [ ]  Physical aggression

[ ]  Substance use [ ]  Psychosis [ ]  Runaway

[ ]  Danger to others [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Describe problematic behaviors that warrant this level of care, occurring within the last 30 days. Provide detailed information to include duration, frequency, intensity, impact, and setting in which the behaviors occur.*

*Describe the individual’s current functioning over the last 7-14 days, including current medications or recent changes to medications, as well as the individual’s ability to care for self and complete activities of daily living.*

*Describe any pertinent background information, including exposure to trauma.*

*Describe any legal history or court involvement (court ordered treatment, probation). Detail the criminal charge(s), when and where they occurred, along with the disposition.*

Proposed Targeted Treatment Goals:

Tentative Discharge Plan (living arrangement, services, and barriers):

***Document all known past and current behavioral health services (inpatient, outpatient, in-home, etc.):***

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| --- | --- | --- | --- |
| **Service** | **Dates** | **Provider** | **Outcome** |
|       |       |       |       |
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***Attach the following documents:***

* Most recent psychiatric and/or psychosocial assessment
* Child and Adolescent Needs and Strengths (CANS) assessment
* Comprehensive Diagnostic Assessment (CDA)
* Court order for treatment (if applicable)
* Individualized education plan or 504
* List of current medications
* Recent progress notes from current service providers
* Psychological or neuropsychological completed within the last 12 months

*If a youth (through the month of their 21st birthday) needs medically necessary services that are not covered under the Idaho Behavioral Health Plan (IBHP), see IDAPA 16.03.09.880. Additional services may be approved through the Early Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, 42 CFR § 440.345.*