

Psychiatric Residential Treatment Facilities Prior Authorization Request

Aetna Better Health of Kansas
Fax: 1-855-225-4102
Children's Mercy Pediatric Care Network
Fax: 1-888-670-7260

Sunflower Health Plan
Fax: 1-844-824-7705

United Healthcare/OptumHealth
Fax: 1-855-268-9392

Member information

Member name: Select here to enter text.
Medicaid/ID number: Select here to enter text.
Member DOB: Select here to enter text.
Other health insurance: Select one.
If yes, please list carrier(s)/policy number(s): Select here to enter text.
Member's current living situation: Choose an item.

Member's current custody status: Choose an item.
Name of parent/legal guardian: Select here to enter text.
Phone number for parent/legal guardian: Select here to enter text.
Current mailing address for parent/legal guardian: Select here to enter text.

Acute Level

(Checking any one of the following may exclude from admission to PRTF unless the PRTF has the capacity to provide care in such situations, for example, 1:1 staffing, crisis management, 24/7 nursing and physician coverage):

- Acutely suicidal or homicidal, acutely psychotic OR
- Acute substance use issues, OR
- Acute medical issues.

Referring concern/presenting problem

Child's current signs and symptoms meet criteria for a DSM diagnosis not solely due to Intellectual or Developmental Disability (IDD) and/or alcohol or drug use.

Statement of concern: Select here to enter text.

Current behavioral health diagnoses: Select here to enter text.

Primary: Select here to enter text.

Secondary: Select here to enter text.

Dual diagnosis (i.e., intellectual disability, autism spectrum, substance abuse): Please add comments regarding specific treatment needs. Select here to enter text.

Current medications: Select here to enter text.

Behaviors/symptoms of concern for the last 60 days

(Mark all that apply to indicate acuity and chronicity of behaviors. Please describe frequency, intensity, duration of the behaviors in the last 60 days for each box checked in the text box.)

- Aggressive or assaultive behavior causing substantial harm to self, others, animals, or property, unresponsive to adult de-escalation or direction Select here to enter text.
- Unable to maintain behavioral control for more than 48 hours that may cause acute risk of substantial harm to self or others or substantial dysfunction in the community Select here to enter text.

- Pervasive rejection of adult requests, directions, and rules that puts the child or others at risk for substantial harm or dysfunction in the home, school or community [Select here to enter text.](#)
- Hostile, threatening or intimidating behavior resulting in fear response in others
[Select here to enter text.](#)
- Delusions/hallucinations/psychotic symptoms causing substantial dysfunction in daily living
[Select here to enter text.](#)
- Fire setting/repeated property destruction [Select here to enter text.](#)
- Chronic non-suicidal, injurious behaviors [Select here to enter text.](#)
- Chronic suicidal and/or homicidal ideas, plans and/or behaviors [Select here to enter text.](#)
- Repeated arrests or confirmed illegal activity related to the psychiatric diagnosis that could place self/others at risk for substantial harm [Select here to enter text.](#)
- Poor impulse control that does/could result in substantial harm to self or others and is unresponsive to adult intervention [Select here to enter text.](#)
- Runaway that places self at risk for substantial harm [Select here to enter text.](#)
- High-risk sexually inappropriate or abusive behavior [Select here to enter text.](#)
- Support system unable or unavailable to manage intensity/safety regarding eating disorder symptoms [Select here to enter text.](#)
- Substance use that exacerbates other psychiatric symptoms [Select here to enter text.](#)

Summary of how the items checked impacts the request. Please add any additional comments that supports medical necessity for PRTF admission. [Select here to enter text.](#)

Current treatment/support services (utilized within less than 30 days) Community resources have been determined to not meet the current treatment needs of the child in the past 30 days, as evidenced by meeting ONE of the boxes (1-2) below:

- 1. The child’s Community-Based Services Team (CBST) or current treatment team believes that all available and appropriate intensive community services have been tried without sufficient success for at least 30 days, by meeting BOTH boxes (a-b) below:

- a. In addition to therapy and medication management child has participated in community services for at least 30 days, please address all listed services below:

Intensive outpatient program

- not applicable
- not available

If applicable, describe frequency, intensity, duration: [Select here to enter text.](#)

Substance abuse treatment — residential

- not applicable
- not available

If applicable, describe frequency, intensity, duration: [Select here to enter text.](#)

Substance abuse treatment — outpatient

- not applicable
- not available

If applicable, describe frequency, intensity, duration: [Select here to enter text.](#)

Serious emotional disturbance waiver services

- not applicable
- not available

If applicable, describe frequency, intensity, duration: [Select here to enter text.](#)
Community-based services (CPST, TCM, Psychosocial, etc.)

- not applicable
- not available

If applicable, describe frequency, intensity, duration: [Select here to enter text.](#)
Qualified Residential Treatment Program or Youth Resource Center II

- not applicable
- not available

If applicable, describe frequency, intensity, duration: [Select here to enter text.](#)
Therapy (i.e., individual, family, group)

- not applicable
- not available

If applicable, describe frequency, intensity, duration: [Select here to enter text.](#)
Medication management

- not applicable
- not available

If applicable, describe frequency, intensity, duration: [Select here to enter text.](#)
Family preservation

- not applicable
- not available

If applicable, describe frequency, intensity, duration: [Select here to enter text.](#)
Intellectual/developmental disability services

- not applicable
- not available

If applicable, describe frequency, intensity, duration: [Select here to enter text.](#)
Crisis Services at the community level

- not applicable
- not available

If applicable, describe frequency, intensity, duration: [Select here to enter text.](#)

If member currently receives services from a community mental health center (CMHC), please identify the CMHC, the service(s) and length of time engaged in services: [Choose an item.](#)

b. Intensive community services have not produced substantive improvement in the child's behaviors and/or psychiatric symptoms.

2. The child's psychiatric and/or psychosocial condition prohibit the child from utilizing community services, by meeting ONE of the boxes below:

Multiple inpatient admissions prohibit child from utilizing consistent community services. Summarize how this impacts the request. [Select here to enter text.](#)

Child's behaviors/psychiatric condition are so severe that they prohibit child from utilizing consistent community services. Summarize how this impacts the request [Select here to enter text.](#)

The families, schools, or community's efforts to manage the child's behaviors have exhausted all available and accessible resources. Summarize how this impacts the request [Select here to enter text.](#)

Other, please indicate any other barriers to community based services. Select here to enter text.

Summary of how the items checked impacts the request. Please describe frequency, intensity, duration of the behaviors checked. Select here to enter text.

How has information been gathered? Face to face, televideo, phone call

Barriers to treatment: Please list any known barriers to providing outpatient services (example: member location does not have the needed services available, member/guardian's refusal to engage in services, not currently living in a community setting, etc.). Select here to enter text.

PRTF services can be reasonably expected to improve the child's chronic condition or prevent further regression so that services will no longer be needed, as evidenced by meeting at least ONE of the boxes below:

- PRTF treatment is expected to increase the child's capacity to form therapeutic relationships and collaborate in their treatment, OR
- PRTF treatment is expected to increase the child's capacity to collaborate with their parents, teachers, coaches and other adults in their life, OR
- PRTF treatment is expected to increase the child's capacity to relate with peers in safe, satisfying and meaningful ways.

Treatment team's goals for PRTF treatment

Select here to enter text.

Discharge Plan if the child meets this level of care

Medical Services

Select here to enter text.

Behavioral Services

Select here to enter text.

Educational Needs

Select here to enter text.

Developmental Needs

Select here to enter text.

Psychosocial Needs

Select here to enter text.

Legal Needs

Select here to enter text.

Assessed for waiver needs

Select here to enter text.

If member currently receives services from a community mental health center (CMHC), please identify the CMHC, the service(s) and length of time engaged in services: Choose an item.

Current physical health conditions/concerns

- Pregnant — number of weeks: Select here to enter text.
- Diabetes — insulin dependent: Select one (Y/N).
- History of traumatic brain injury
- Seizure disorder: Select here to enter text.
- Other (please describe): Select here to enter text.

Inpatient/residential treatment history

Please select all that apply:

- Inpatient psychiatry; dates if known: Select here to enter text.
- Psychiatric residential treatment facilities (PRTFs); dates if known: Select here to enter text.
- Substance abuse treatment — residential; dates if known: Select here to enter text.

Educational history

Currently in school: Select one.

Current grade level: Select here to enter text.

Alternative school: Select one.

Current individual education plan/504 plan: Select one.

Other school-based services/supports: Select one. If yes, please describe: Select here to enter text.

Full scale intelligence quotient (if known): Select here to enter text.

Other relevant educational history: Select here to enter text.

Placement history less than 60 days

Select here to enter text.

Other services that could be provided upon diversion

- Intensive outpatient program
- Substance abuse treatment
- Serious emotional disturbance waiver
- Community-based services
- Therapy (i.e., individual, family, group)
- Medication management
- Family preservation
- Intellectual/developmental disability services
- Crisis Services at the community level
- Other, please describe: Select here to enter text.

Assessor's recommendation for treatment and justification for decision

Select here to enter text.

Completed by: Select here to enter text.

Agency: Select here to enter text.

Name/job title/Credentials: Select here to enter text.

Phone number: Select here to enter text.

Fax Number: Select here to enter text.

Date: Select here to enter a date.

If approved for the PRTF level of care, please list the PRTFs that the parent/guardian agreed to have their child referred to and MCO releases of information have been completed.

- KidsTLC
- EmberHope
- Florence Crittenton
- Camber - Hays
- Camber - Kansas City
- Lakemary Center
- Pathways Family Services
- Prairie View

St. Francis