

## Checklist of Supporting Materials for Pre-admission Certification Committee Review

**CHECKLIST OF SUPPORTING MATERIALS:** In order to prevent delay in processing this application, please fill out the identifying data completely and submit all the required information. (All materials listed below are required to determine RTF eligibility and Medicaid disability). According to the region of the PACC, please submit the following number of collated copies: WESTERN REGION, 5 collated copies (1 original, 4 copies) > NYC, 5 collated copies (1 original, 4 copies) > LI, 2 collated copies (1 original, 1 copies) > HR 2 collated copies (1 original, 1 copies) > Central, 4 collated copies (1 original, 3 copies)

1. COVER "ACCESSING A RESIDENTIAL TREATMENT FACILITY Via SPOA

2. CONSENTS / RELEASE FORMS FOR:

- Application for an RTF review by PACC
- Release of information signed by parent/guardian or where appropriate, the child/youth which give the PACC permission to refer to and release information to RTF providers
- disability determination
- release of info to the committee on special education
- COPY OF BIRTH CERTIFICATE, HEALTH INS. CARD(S) (Back & Front)

3. **REFERRAL SUMMARY:** Attached is a brief summary of the most salient features of the case, including examples and descriptions of behaviors that typify the youth's response to current placement. Include current information regarding performance of age-appropriate activities, interests, self-care skills, ability to relate to others, and certification by a mental health professional who is familiar with the case that the materials attached accurately reflect the youth's current level of functioning. In summary, why RTF level of care will serve the needs of the child.

4. **PSYCHIATRIC SUMMARY:** Attached is a copy of the most recent psychiatric examination (Date: \_\_\_\_\_) which includes a current mental status, history of prior psychiatric care and treatment, diagnostic formulation (with clear examples that substantiate clinical tenets), DSM IV/V diagnosis, prognosis, and a brief summary of past and present psychotropic medication and its effectiveness. *A full psychiatric examination must have been performed within the last year, with an update within the past 90 days of the time of referral, verifying that the psychiatric examination accurately reflects the youth's current level of functioning. The update must be completed by the treating MD. – PACC may request an updated psychiatric under 90 days based upon the youth's current clinical status.*

5. **PSYCHOLOGICAL SUMMARY:** Attached is a copy of the most recent psychological assessment (Date: \_\_\_\_\_) which includes an assessment of sensory-motor functioning, mental status, prior history of psychological problems, behavioral skills and deficits, language cognition, self-help skills, social-affective functioning, intellectual functioning (including IQ), and prognosis. Where available, an assessment of psychodynamic functioning including tentative etiology and response to prior treatment efforts is attached. Where appropriate, clear descriptive examples that substantiate clinical tenets should be provided. *The psychological examination should accurately reflect the youth's current level of functioning. The full psychological examination should be signed by a licensed psychologist and performed within the past 2 – 3 years.*

6. **PSYCHO-SOCIAL** which also includes the following:

a) **DEVELOPMENTAL HISTORY:** Attached is an assessment of the youth's developmental history which includes, where available and appropriate, an assessment of pre-, peri-, and post-natal periods, developmental milestones and problems, and problems and experiences which have interfered or may interfere with future development, peer relationships, and/or activities

b) **ENVIRONMENTAL/FAMILY/SOCIAL STATUS:** Attached is an assessment of family and community relationships, and where appropriate and available, characteristics of interactions with peer groups and adults, socioeconomic status, constellation of family group, emotional and health factors of the family, religious, and ethnic affiliation, current and past family problems, family's expectations and predicted involvement in treatment. *(An assessment of the family must have been performed within the last year)*

7. **EDUCATIONAL/VOCATIONAL SUMMARY:** Attached is an assessment of current and former school status and vocational assets/liabilities which include, where available and appropriate, intellectual or achievement test results, general classroom behavior, relationship with teachers and peers, ability to finish work, accuracy of work, use of free time, motivation, effective incentives/reinforcers (*it should be noted whether or not the applicant has been reviewed by a CSE; if so, their recommendations and at least Phase I of an IEP should be attached*), current work skills and potential for improving or developing new skills, amenability to vocational counseling, aptitude, interests and motivation for getting involved in various job-related activities, physical abilities, skills and experience in seeking jobs. *(An Education/Vocational summary must have been performed within the last six months.)*

4. **PHYSICAL STATUS:** Attached is a summary and most recent assessment (Date: \_\_\_\_\_) of the youth's physical status. Materials include a statement of general overall health, general physical exam, dental and vision assessments, and where appropriate and available, a neurological exam, serology and hemoglobin reports, urinalysis, chest x-ray or tyne test report, nutritional assessment and any other physical findings. *(A physical examination must have been performed within the past year, unless there is an ongoing medical problem, in which case, within 30 days of the time of referral.)*

The following is not required for PACC review but mandatory for RTF Admission if eligible

- IMMUNIZATION RECORD
- SOCIAL SECURITY CARD (copy)

Drafted: 11/12/13



**CONSENT FOR REVIEW BY THE WESTERN NEW YORK PREADMISSION CERTIFICATION COMMITTEE FOR POSSIBLE PLACEMENT INTO A RESIDENTIAL TREATMENT FACILITY/DISABILITY DETERMINATION**

Youth's Name: (Last) (First) (M.I.) Youth's Date of Birth

Youth's Address:

Agency Name:

Agency Address:

I consent to the release of clinical and educational information to the Western New York Preadmission Certification Committee. I understand that the Western New York Preadmission Certification Committee will review and evaluate this information to determine youth's eligibility for services in a Residential Treatment Facility.

Furthermore, I authorize the Western New York Preadmission Certification Committee to release clinical/educational information, and to refer to the appropriate Residential Treatment Facility (s) for possible placement.

In addition, I authorize the Western New York RTF Case Manager to obtain additional information from hospitals, mental health agencies, school districts, and other service providers were applicable to determine eligibility for Residential Treatment Facility placement.

It is understood that this information will be used to evaluate the youth for possible placement into a RTF and that the Preadmission Certification Committee and the RTF (s) will maintain the confidentiality of this information.

I also understand that I have the right to cancel my permission to release the information or withdraw from the RTF referral process any time before the information is released. This consent to release information will expire a) one (1) year from the signed date if youth is not admitted into an RTF or b) when the youth is discharged from an RTF. The PACC may request updated consents to continue the referral/placement process.

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Signature of Youth (where appropriate & available)

Signature of Parent/Legal Guardian

Relationship

Print Name Signed

Date Signed

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Signature of Witness

Title

Print Name Signed

Date Signed

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Signature of Person Completing Form

Date Signed

Print Name Signed

Date Signed

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CONSENT FOR THE WESTERN NEW YORK PRE-ADMISSION CERTIFICATION COMMITTEE TO RELEASE INFORMATION TO THE COUNTY MENTAL HEALTH DEPARTMENT

Youth's Name: (Last) (First) (M.I.) Youth's Date of Birth

Youth's Address:

Agency Name:

Agency Address:

I authorize Western New York Pre-Admission Certification Committee to release Name, Date of Birth, Services Presently Receiving, Guardian(s)/Custodians Name, Address and Telephone Number and pertinent information to assist in treatment of the above named youth to the County Mental Health Department in the county that I reside in including the Single Point of Accessibility SPOA program for the County which may be administered by a contracted service organization.

It is understood that this information will be used to assist in possibly planning and providing appropriate services prior to possible placement into an RTF as well as planning for your child's discharge from the RTF. The Pre-Admission Certification Committee and the County/SPOA will maintain the confidentiality of this information.

I also understand that I have the right to cancel my permission to release the information to the County Mental Health/SPOA any time before the information is released. This consent to release information will expire a) one (1) year from the signed date if youth is not admitted into an RTF or b) when the youth is discharged from an RTF. The PACC may request updated consents to continue the referral/placement process.

Signature of Youth (where appropriate & available)

Signature of Parent/Legal Guardian

Relationship

Print Name Signed

Date Signed

Signature of Witness

Title

Print Name Signed

Date Signed

Signature of Person Completing Form

Date Signed

Print Name Signed

Date Signed

### REQUEST FOR DISABILITY DETERMINATION

Name of Youth: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

This is to request that a Preadmission Certification Committee designed by the Office of Mental Health and the Department of Social Services determine whether the above named youth is disabled for purposes of the Medical Assistance Program.

I authorize the PACC to review and evaluate any clinical information it has received to assess whether the above named youth is disabled. I also authorize the PACC to make any investigation necessary to confirm or verify this information or to collect additional information necessary to determine whether he/she is disabled.

I understand that this form is not a reapplication for Medical Assistance benefits, and that the PACC will be deciding whether the above named youth is disabled but not whether he/she is eligible for Medical Assistance.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Relationship to Applicant

\_\_\_\_\_  
Date

This consent to release information will expire:

- One (1) year from the signed date if youth is not admitted into an RTF or
- When the youth discharged from an RTF

CONSENT FOR RELEASE OF INFORMATION TO THE  
COMMITTEE ON SPECIAL EDUCATION

4

Name of Youth: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I authorize the Western New York Preadmission Certification Committee and/or the Western Region RTF Case Manager to release and/or obtain the following information regarding the above named youth:

\_\_\_\_\_ Psychological Evaluation

\_\_\_\_\_ Psychiatric Evaluation

\_\_\_\_\_ Psychosocial History

\_\_\_\_\_ Physical/Medical Information

\_\_\_\_\_ Individual Educational Plan (IEP)

\_\_\_\_\_ Other (please identify): \_\_\_\_\_  
\_\_\_\_\_

To/from the following school Districts:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Print Name Signed

\_\_\_\_\_  
Date Signed

This consent to release information will expire a) one (1) year from the signed date if youth is not admitted into an RTF or b) when the youth is discharged from an RTF.

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Title

\_\_\_\_\_  
Print Name Signed

\_\_\_\_\_  
Date Signed

# SPOA & Residential Treatment Facility REFERRAL MATERIAL

State of New York  
OFFICE OF MENTAL HEALTH

## SPOA COVER SHEET

To be completed and used by the SPOA when submitting an application to the RTF Case Manager

Last  
 First  
 DOB

COUNTY:

SPOA Supports the RTF Application. *(Explain in Narrative)*  
 SPOA Does Not Support the RTF Application ; however, Parents/Guardians requesting that RTF Eligibility be Pursued. *(Explain in Narrative)*

Services Received (check all that apply):  Hospital  Acute  State

✓ Residential

<input type="checkbox"/> RTF	<input type="checkbox"/> Group Home
<input type="checkbox"/> RTC	<input type="checkbox"/> FBT
<input type="checkbox"/> RTC Critical Care	<input type="checkbox"/> Therapeutic Foster Care
<input type="checkbox"/> CR	<input type="checkbox"/> Other _____

✓ Outpatient Services

<input type="checkbox"/> Waiver	<input type="checkbox"/> Day Treatment	<input type="checkbox"/> Wraparound
<input type="checkbox"/> SCM	<input type="checkbox"/> Therapy (clinic or private)	<input type="checkbox"/> Care Coordination
<input type="checkbox"/> ICM	<input type="checkbox"/> None	
<input type="checkbox"/> ICM+	<input type="checkbox"/> Other _____	

✓ Other Agencies Involved

OMRDD  OCFS  OASAS

Parents were offered information about Family Support and/or how they can contact a family advocate:

Yes  
 No

**ATTACH PAGES THAT EXPLAIN, IN A NARRATIVE, THE FOLLOWING INFORMATION:**

- REASON FOR THE REFERRAL
- WHY LOWER LEVELS OF CARE HAVE BEEN UNSUCCESSFUL
- EXPECTED OUTCOMES - INCLUDE DISCHARGE PLAN FOLLOWING RTF PLACEMENT
- DOES FAMILY/GUARDIAN AGREE WITH DISCHARGE DIRECTION

SPOA Coordinator Signature \_\_\_\_\_ Date \_\_\_\_\_

Residential Treatment Facility/Medicaid Determination

State of New York  
OFFICE OF MENTAL HEALTH

REFERRAL MATERIAL

# REFERRAL SUMMARY

Referral Summary  Yes  No

SPOA Contacted:  Yes  No

FOR OFFICE USE ONLY:

Birth Cert.  Health Ins. Card  SS Card  Cover  Consents  SPOA  Referral Summary  Psychiatric  Psychological  Psychos

**Abstract:**

**SPOA & Residential Treatment Facility  
REFERRAL MATERIAL**

# PSYCHIATRIC SUMMARY

**Psychiatric Evaluation Included?**

*Includes a Multi-Axis Diagnosis & Signed by a psychiatrist!*

YES  NO

**Psychiatric Update within the past 90 days?**

*Includes an Evaluation with Multi-Axis Diagnosis & Signed by a psychiatrist!*

YES  NO

**Primary Axis1 Diagnosis:**

**Axis 1:**

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**Axis2:**

**Axis3:**

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**Axis4**

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**Axis5**

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**Attach Supporting Documentation:**

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**SPOA & Residential Treatment Facility  
REFERRAL MATERIAL**

# PSYCHOLOGICAL SUMMARY

Psychological Evaluation Attached:  Yes  No

Full Scale IQ: _____	Verbal IQ: _____
	Performance IQ: _____

Psychological Evaluation Date: \_\_\_\_\_

Attach Supporting Documentation:

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# PSYCHOSOCIAL SUMMARY

**Psychosocial Summary  
Including FAMILY HISTORY and  
DEVELOPMENTAL INFORMATION  
is Attached:**

Yes  No

**Attach Supporting Documentation:**

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**SPOA & Residential Treatment Facility  
REFERRAL MATERIAL**

# EDUCATIONAL SUMMARY

Educational Summary Attached:  Yes  No

Youth's Individualized Educational  
Plan (IEP) is Attached:  Yes  No

Attach Supporting Documentation:

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**SPOA & Residential Treatment Facility  
REFERRAL MATERIAL**

# PHYSICAL STATUS

Medical Summary Attached:  Yes  No

Immunization Record Attached:  Yes  No

Attach Supporting Documentation:

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