



"People helping people help themselves"

Division of Mental Health and Addiction
 402 W. WASHINGTON STREET, ROOM W353
 INDIANAPOLIS, IN 46204-2739
 317-232-7800
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**Community-Based Options for Youth and Families
 Psychiatric Residential Treatment Facilities (PRTF) Transition Waiver
 Level of Care Review Form**

Maintain the original review form and supporting documentation in Participant's master file. Fax a copy of the completed Level of Care (LOC) Review form, along with all relevant attachments, to:

PRTF Transition Waiver
 Indiana Family & Social Service Administration
 Division of Mental Health & Addiction
 Confidential Fax: 317 233-1986

Type of Level of Care Determination

Please check one: Annual Redetermination: Slot # _____
 Reentry: Slot # _____

IDENTIFYING INFORMATION:

Child's Name	(Last)	(First)	(MI)
Date of Birth	___/___/_____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Race: <input type="checkbox"/> American Indian/Native Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Other	
SSN: _____ - _____ - _____		Medicaid (RID) #	
Current Address	<input type="checkbox"/> Family Home <input type="checkbox"/> Relative's Home <input type="checkbox"/> Foster Home <input type="checkbox"/> Therapeutic Foster Home <input type="checkbox"/> Group Home <input type="checkbox"/> Detention/Jail <input type="checkbox"/> Hospital <input type="checkbox"/> PRTF <input type="checkbox"/> Homeless <input type="checkbox"/> Secure Residential <input type="checkbox"/> DOC <input type="checkbox"/> Open Residential <input type="checkbox"/> Other: _____ Name of Facility: _____		
(Street)			
(City)	(County)	(State)	(Zip)
Telephone	()		
Signature of Legal Guardian:		Date:	
DMHA ONLY- Completed form received ___/___/_____ Time ___:___ <input type="checkbox"/> AM <input type="checkbox"/> PM			



Participant's Name:

Slot#:

CAREGIVER IDENTIFYING INFORMATION:

Relationship to child: Parent Step-parent Adoptive Parent Grandparent Live-in Friend/relative
 Foster Parent Other:

Name (Last) (First) (MI)

Preferred Language of Communication: English Spanish Other: _____

Current Address (Street)

(City) (County) (State) (Zip)

Telephone(s) Home: () Cell: ()

Email Address

Signature of Caregiver: Date:

SECOND CAREGIVER IDENTIFYING INFORMATION (if applicable):

Relationship to child: Parent Step-parent Adoptive Parent Grandparent Live-in Friend/relative
 Foster Parent Other

Name (Last) (First) (MI)

Preferred Language of Communication: English Spanish Other:

Current Address (Street)

(City) (County) (State) (Zip)

Telephone(s) Home: () Cell: ()

Email Address

Signature of Caregiver: Date:

PROBATION OFFICER IDENTIFYING INFORMATION (if applicable):

Name (Last) (First) (MI)

Address (Street)

(City) (County) (State) (Zip)

Email Address Phone ()

DCS FAMILY CASE MANAGER IDENTIFYING INFORMATION (if applicable):

Name (Last) (First) (MI)

Address (Street)

(City) (County) (State) (Zip)

Email Address Phone ()

CHINS/Ward: NO YES Case Number:

Have parental rights been terminated? NO YES

Participant's Name:

Slot#:

DETERMINATION OF ELIGIBILITY CRITERIA:

1. AGE: Is the child at least 6 years but not yet 21 years old?

YES

NO (Complete Section 5 only)

2. CANS ASSESSMENT RESULTS AND RECOMMENDATION:

Use Indiana CANS 5 to 17 tools for all children & youth wanting to access grant services

Version of CANS: Comprehensive CANS Reassessment

Date of Assessment: ___/___/_____ (Evaluation must be within last 90 days.)

Attach report from Data Assessment Registry Mental Health & Addiction (DARMHA)

CANS ASSESSMENT BEHAVIORAL HEALTH RECOMMENDATION:

Option 1: Outpatient

Option 2: Outpatient with Limited Case Management

Option 3: Supportive Community Services

Option 4: Intensive Community-Based Services: Wraparound

Option 5: PRTF Transition Waiver

Option 6: PRTF/ SOF/ PRTF Transition Waiver

Certified CANS Super User submitting this assessment:

(Name and Credentials)

(Date of last Super User Booster Session)

(Agency)

(Telephone)

3. ** RE-ENTRY ASSESSMENT:

Recommendation is Option 5 or 6. Child meets criteria for Waiver.

Recommendation is *not* Option 5 or 6. Child does not meet criteria for Waiver. (Complete Section 5 only)

(Note: Alternate service recommendation(s) to be offered to family for service(s) that meets youth's identified level of need.)

**** ANNUAL REDETERMINATION:**

Recommendation is Option 5 or 6. Child meets criteria for Waiver.

Recommendation is *not* Option 5 or 6. Child does not meet criteria for Waiver, but may transition out of the program during a 3-month transition period. (Complete Section 5 only)

(Note: Last date of authorized transition service will be 3 months from date of the CANS assessment.)

Participant's Name:

Slot#:

4.

FEASIBILITY AND SAFETY OF COMMUNITY BASED CARE:

I certify that community-based care is:

- safe and feasible.
- not safe or feasible in regard to the health and welfare of the child/youth at this time.

If not *safe or feasible*, explain concerns:

Documentation of Feasibility and Safety completed by: OBHP Physician



Signature			Date:
Printed Name	Telephone: ()		
Agency			
Address	(Street)		
(City)	(State)	(Zip)	
(Email)			

5.

CRITERIA STATUS (Select all applicable choices):

****RE-ENTRY APPLICATION:**

- Child is between ages 6-20 years old
- Child has a CANS score of 5-6
- Child has Medicaid
- Child is safe and feasible in the community
 - Participant **meets criteria** for Waiver.
 - Participant **does not meet criteria** for Waiver—indicate alternate service recommendation(s) below.

****ANNUAL REDETERMINATION:**

- Child is between ages 6-20 years old
- Child has a CANS score of 5-6
- Child has Medicaid
- Child is safe and feasible in the community
 - Participant **meets criteria** for Waiver.
 - Participant **does not meet criteria** for Waiver.
 - Participant **does not meet criteria** for waiver, but may transition out of the program during a **3-month transition period**.

If the Participant does NOT meet the Waiver criteria, indicate the services offered as an alternative:

6.

STATEMENT OF FREEDOM OF CHOICE

I have been fully informed of the services available to me in a PRTF setting. I understand the alternatives available and have been given the opportunity to choose between PRTF Transition Waiver services and PRTF care. As long as I remain eligible for PRTF Transition Waiver services, I will continue to have opportunity to choose between Waiver services in home and community-based setting or placement in a PRTF.

At this time I have chosen to receive PRTF Transition Waiver services in home and community-based settings, rather than PRTF placement.

At this time, I have chosen to receive PRTF Transition Waiver services rather than Hoosier Healthwise Managed Care services.

I have been informed of my right to choose any DMHA approved PRTF Transition Waiver provider when selecting service providers.

OR

At this time I have chosen to receive services in a PRTF setting, rather than PRTF Transition Waiver services in home and community-based settings.

Signature of participant/guardian: _____

Date signed: _____



7.

FAMILY NOTICE OF EVALUATION:

- I have been informed by the Wraparound Facilitator of the PRTF Transition Waiver evaluation processes. I have been encouraged to participate.
- I understand that if I choose to participate, it will help evaluate the effectiveness of community-based services.
- I understand that I will receive a letter from the evaluator with additional information about the evaluation and an invitation to participate.
- I know that if I decide to participate in the evaluation, I will be contacted to complete the Wraparound Fidelity Index survey by phone.
- I know that if I decide to participate in the evaluation, I will also be asked to complete the Youth Services Survey by mail or by phone.

Signature of participant/guardian: _____ Date signed: _____



PRTF TRANSITION WAIVER LOC REVIEW FORM PREPARED BY:

Signature			Date
Printed Name	Telephone ()		
Agency			
Address	(Street)		
(City)	(State)	(Zip)	
Email			



