Application for Residential Treatment Center Placement

(Must be completed by family)

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information required by Health Net Federal Services, LLC (Health Net) on behalf of the TRICARE program, and how it will be used.

AUTHORITY: 10 U.S.C. Chapter 55; 38 U.S.C. Chapter 17; 32 CFR Part 199, and E.O.9397 (SSN), as amended.

PURPOSE: To collect information from you in order to manage your TRICARE enrollment, provide your benefits and/or pay for those services.

ROUTINE USES: Your information may be disclosed in order to investigate waste, fraud and abuse, security, and privacy concerns. Use and disclosure of your records outside of DoD may occur in accordance with the DoD Blanket Routine Uses published at http://dpclo.defense.gov/privacy/SORNs and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Any protected health information (PHI) in your records may be used and disclosed as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), and includes purposes of treatment, payment, and health care operations.

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 intensive outpatient measures (multiple weekly visits), family therapy and/or acute inpatient admissions. 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.

For questions on the RTC benefit, help locating KEPRO-certified facilities or assistance completing this form, please contact 1-844-866-WEST (9378). Submit this application and all supporting documentation via fax to 1-844-818-9289.

Family Therapy Agreement

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.

- Family involvement is essential to your child's success while in a RTC. If you live less than 250 miles from the residential treatment facility, you are expected to be onsite weekly for a family session with your child's therapist. If you live more than 250 miles away, you are required to either participate in family therapy onsite or participate in Geographically Distant Family Therapy (GDFT).
- If you participate in GDFT you will attend family therapy sessions **at a therapist's office** near your home three times per month and onsite monthly. The GDFT therapist will conduct the session telephonically with you, your child and his/her therapist at the RTC.
- You are required to attend one family therapy session per month at the RTC. There is no copayment for the family for GDFT. GDFT is expected to begin with the first two weeks of the patient's admission to the RTC. Failure to comply with family therapy requirements may result in denial of continued authorization and discharge from the RTC.

I agree to comply with the requirements of family therapy and onsite visits listed above.

Parent/Guardian Signature: _____ Date:_____

Parent/Guardian Signature: _____ Date:_____

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?

What is your expectation of the RTC admission including where the child will return after treatment?

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):

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

Involvement of Other Agencies

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 (for example, Medicaid):

Treatment within the Last 12 Months

Type Service (inpatient; PHP; RTC; IOP; outpatient individual, group and/or family therapy)	**Provider/Facility Name**	**Approximate Dates of Service**	**If outpatient, how many times per week?**

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

This residential treatment center application is for: _____
(Name of child)

_____ _____
(Parent/Guardian) (Parent/Guardian)

_____
(Date)

Prohibition on redisclosure: Further disclosure of information by the appointed representative may only be made in accordance with the provisions of the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and other applicable Federal law.