Psychiatric Residential Treatment Facility (PRTF)
Admission Review Form

1.1 APS ID #	***1.6*** MH CID #
1.2 Social Security #	***1.7*** Requested PRTF- Facility Name
1.3 Medicaid ID #	***1.8*** Facility ID #
1.4 Consumer Last Name	***1.9*** Date of Birth / / — ***1.10*** Gender ☐Male ☐Female
Consumer First Name M.I.	***1.11*** **Core Provider Information**
1.5 Residential Address Line 1	Agency Name
City	Agency PVGA#
State / Zip Code	UR Contact - Last Name
Child's County of Legal Residence	UR Contact- First Name
1.12 **Payor/Funding Source** *(Check all that apply)*	Office Phone
☐ Medicaid (MRO) ☐ Medicaid (CMO) ☐ Indigent/State Funded ☐ Other	Assessment Date: / / Assessment Time: :

1.13 **Current Legal Status**

a. Legal Custody: *(Check any that apply)*	☐ DFCS Custody	☐ Other Court-Appointed Guardian: ______________	☐ Parental Custody ☐ DJJ
b. Legal Involvement *(Check all that apply)*	☐ DFCS ☐ Jail/Law Enforcement	☐ Treatment Court (MH/AD) ☐ Probate Court	☐ Juvenile Justice ☐ Juvenile Court Order
c. Agency Requiring Consumer Services: *(Check all that apply)*	☐DFCS ☐ Jail/Law Enforcement	☐ Juvenile Justice ☐ Adult Criminal Court	☐ Treatment Court (MH/AD) ☐ Probate Court ☐ Adult Probation ☐ Parole
d. Justice System Involvement	Has consumer been involved with criminal/juvenile justice system in the past year? ☐ Yes ☐ No (Includes arrests, probation, parole, commitments, adjudications, diversions, or awaiting sentencing)		
e. Arrests:	Number of arrests, regardless of nature of offense or outcome, in the past 90 days		

1.14 PRTF Admission Date:
(To be completed by the PRTF)

Admission Date:
/ /

Admission Time:
:

1.15 CAFAS	
Date Administered	/ /
School/Work	
Home	
Community	
Behavior/Others	
Moods/Emotions	
Self-Harmful Behavior	
Substance Use	
Thinking	
Total Score	

1.16 Admission Diagnosis:		
Axis I Diagnosis (Primary) .	Axis II Diagnosis (1) .	Axis III Diagnosis (2) .
Axis I Diagnosis (Secondary) .	Axis II Diagnosis (2) .	IQ Score
Axis I Diagnosis (Tertiary) .	Axis III Diagnosis (1) .	M-GAF

1.17 Risk Symptoms & Behaviors necessitating placement into a Psychiatric Residential Treatment Facility (PRTF)

Clinical Status

1.	Does the consumer require residential treatment due to behavioral, emotional and family problems that cannot be addressed safely/adequately in the community/home?	Yes ☐	No ☐
2.	Does the consumer require intensive, psychiatric treatment to decrease risk factors such as suicidal/homicidal ideation and/or aggressive behavior?	Yes ☐	No ☐
3.	Is the consumer unable to return home or to a temporary residence at night due to psychiatric symptoms?	Yes ☐	No ☐
4.	For at least the past 6 months, has the consumer been served at lower levels of care to address behavior and/or psychiatric symptoms with little/no success, or are those levels of care considered inappropriate due to behavioral health risks?	Yes ☐	No ☐
5.	Is there evidence of significant family dysfunction or social relationship problems due to consumer's behavior and or psychiatric symptoms?	Yes ☐	No ☐
6.	Is there a family history of mental illness and/or substance abuse?	Yes ☐	No ☐
7.	Is the family/caregiver willing to engage and participate in treatment as partners in the consumer's care?	Yes ☐	No ☐
8.	Is the consumer eligible to return to their current home or community placement once they are appropriate to discharge from this LOC?	Yes ☐	No ☐
9.	Is there a pattern of significant disruptive behavior, related to a diagnosed behavioral health disorder, negatively affecting functioning in school, community, or family lasting at least the previous 6 months?	Yes ☐	No ☐
10.	Has the family/caregiver been informed and agreed to participate fully in family therapy sessions as deemed necessary and appropriate?	Yes ☐	No ☐
11.	Does the consumer have a history of sexual offense?	Yes ☐	No ☐
12.	Has the consumer been victimized? *(please check all that apply)* ☐ neglect ☐ physical abuse ☐ sexual abuse	Yes ☐	No ☐
13.	Does the consumer have a substance abuse/dependence issue?	Yes ☐	No ☐

Admission Criteria Narrative *(Please give additional details explaining the symptoms and circumstances which preclude a less restrictive level of care and necessitate the PRTF level of care.)*

1.18 Safety Concerns

Has a safety plan been developed to ensure the consumer's safe transition from a residential placement back to your agency and the community following discharge?	Yes ☐	No ☐

Safety concerns are related to which support deficit? *(Check all that apply)*

☐ Natural supports ☐ Behavioral supports ☐ Medical Supports ☐ School Supports ☐ Living Supports

1.19 **Number of Out-of-Home Placements prior to current admission** *(Please check one)*	☐ 0-3	☐ 3-6	☐ 6-10	☐ More than 10

1.20 Current Symptoms and Severity

Indicate all symptoms/behaviors exhibited within the past 30 days and their level of severity, with one being mild and infrequent and 5 being the most severe and frequent. (see examples in Field Definitions document). All fields must be completed, if the symptom does not apply to this consumer select NA.

Symptom	Severity	Symptom	Severity
Aggressive Behavior	NA☐ 1☐ 2☐ 3☐ 4☐ 5☐	Obsessive/Compulsive	NA☐ 1☐ 2☐ 3☐ 4☐ 5☐
Conduct Problems	NA☐ 1☐ 2☐ 3☐ 4☐ 5☐	Depressed	NA☐ 1☐ 2☐ 3☐ 4☐ 5☐
Oppositional Behavior	NA☐ 1☐ 2☐ 3☐ 4☐ 5☐	Manic	NA☐ 1☐ 2☐ 3☐ 4☐ 5☐
Suicidal Risk	NA☐ 1☐ 2☐ 3☐ 4☐ 5☐	Poor Hygiene	NA☐ 1☐ 2☐ 3☐ 4☐ 5☐
Homicidal Risk	NA☐ 1☐ 2☐ 3☐ 4☐ 5☐	Enuresis/Encopretic	NA☐ 1☐ 2☐ 3☐ 4☐ 5☐
Self Injurious Behavior	NA☐ 1☐ 2☐ 3☐ 4☐ 5☐	Sleep Disturbance	NA☐ 1☐ 2☐ 3☐ 4☐ 5☐
Sexual Acting Out	NA☐ 1☐ 2☐ 3☐ 4☐ 5☐	Appetite Disturbance	NA☐ 1☐ 2☐ 3☐ 4☐ 5☐
Distorted Thinking	NA☐ 1☐ 2☐ 3☐ 4☐ 5☐	Weight Gain/Loss	NA☐ 1☐ 2☐ 3☐ 4☐ 5☐
Hallucinations	NA☐ 1☐ 2☐ 3☐ 4☐ 5☐	Social Withdrawal	NA☐ 1☐ 2☐ 3☐ 4☐ 5☐
Anxious	NA☐ 1☐ 2☐ 3☐ 4☐ 5☐	SA cravings/fixations	NA☐ 1☐ 2☐ 3☐ 4☐ 5☐
Impulsivity	NA☐ 1☐ 2☐ 3☐ 4☐ 5☐	Elopement Attempts	NA☐ 1☐ 2☐ 3☐ 4☐ 5☐

Symptoms Narrative *(please give more detail on all symptoms above that are ≥ 3)*

1.21 What other community behavioral health services have been attempted in the previous six months? *(Check all that apply)*\)

Type of Service	Frequency (Approximate)	*Please indicate the consumer's level of progress and engagement in the services utilized. 1= None, 2= Minimal, 3=Moderate, 4= Significant* Progress	Engagement
☐ MH Day Treatment	☐Daily ☐Weekly ☐Monthly ☐PRN	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐
☐ SA Day Treatment	☐Daily ☐Weekly ☐Monthly ☐PRN	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐
☐ IFI/MST	☐Daily ☐Weekly ☐Monthly ☐PRN	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐
☐ CST	☐Daily ☐Weekly ☐Monthly ☐PRN	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐
☐ Family Therapy	☐Daily ☐Weekly ☐Monthly ☐PRN	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐
☐ Individual Therapy	☐Daily ☐Weekly ☐Monthly ☐PRN	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐
☐ Group Therapy	☐Daily ☐Weekly ☐Monthly ☐PRN	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐
☐ Crisis Intervention	☐Daily ☐Weekly ☐Monthly ☐PRN	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐
☐ CSI	☐Daily ☐Weekly ☐Monthly ☐PRN	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐
☐ Medication Administration	☐Daily ☐Weekly ☐Monthly ☐PRN	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐
☐ Activity Therapy	☐Daily ☐Weekly ☐Monthly ☐PRN	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐
☐ Consumer/Family Assistance	☐Daily ☐Weekly ☐Monthly ☐PRN	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐
☐ Crisis Stabilization	☐Daily ☐Weekly ☐Monthly ☐PRN	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐
☐ Residential Supports (I, II, Other)	☐Daily ☐Weekly ☐Monthly ☐PRN	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐
☐ Respite	☐Daily ☐Weekly ☐Monthly ☐PRN	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐
☐ Other/List: ________________________________	☐Daily ☐Weekly ☐Monthly ☐PRN	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐
☐ Other/List:________________________________	☐Daily ☐Weekly ☐Monthly ☐PRN	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐
☐ Other/List:________________________________	☐Daily ☐Weekly ☐Monthly ☐PRN	1☐ 2☐ 3☐ 4☐	1☐ 2☐ 3☐ 4☐

Previous Treatment Narrative *(please give additional details regarding the reasons previous treatment has not been effective)*

*Please complete the **PRTF Admission Packet Checklist Cover Sheet** and Fax to APS at 1-800-728-6524*