Therapeutic Group Home Application (ThGH)

Please submit this application and all supporting documentation to:
Magellan Behavioral Health
ATTN: Residential Psychiatric Applications
1221 N Street, Suite 325, Lincoln, NE 68508
Phone (800) 424-0333 ~ Fax (866) 848-4942

The completed application must be sent via fax or postal mail. For security reasons, emailed applications will not be accepted.

Clinical Contact Information:	* * * * **Attachments** * * * * **THE FOLLOWING DOCUMENTATION MUST ACCOMPANY THE APPLICATION:**
MIS#	☐ Initial diagnostic interview
Name:	☐ Assessment completed by the Psychiatrist or Licensed Psychologist including: Patient's history of problems and attempted treatment efforts, recommendations of issues to be addressed during ThGH treatment, and recommendation for ThGh level of care. (if available)
Address:	☐ Educational records (most recent IEP and psycho-educational testing, etc.)
City/State/Zip:	☐ Discharge summaries from previous inpatient and outpatient treatment (if applicable)
Phone #:	☐ If requesting sex-offender specific treatment, a curent sex offender risk assessment
Fax #:	☐ If requesting dual (MH/SA) or SA only treatment, a current substance use Disorder evaluation (including ASAM)
Client Information:	☐ Child and Adolescent Needs and Strengths (CANS) assessment (if available)
Name:	☐ Most recent other psychological evaluations (if available)
Date of Birth:	☐ Treating Clinician Statement from all active MH/SA Providers
Medicaid #:	☐ Parent/Guardian Permission for Treatment
Legal Guardian Name: If Client is State Ward, HHS Case Manager Name:	
Legal Guardian Address:	
Legal Guardian City, State, Zip:	
Legal Guardian Phone #:	
Youth Current Residence / Placement:	
State Ward? ☐ Yes ☐ No	
Please indicate if specific treatment is requested for one of the following: ☐ Mental Health Only ☐ Sexual Offender ☐ Mental Health/Substance Use Disorder (Dual)	
Lead Agency Involvement? ☐ Yes ☐ No If **yes**, please provide: Lead Agency: Care Coordinator Name: Care Coordinator Phone #:	Probation Involvement? ☐ Yes ☐ No If **yes**, please provide: Probation Officer's Name: Probation Officer's Phone #:

Answer questions 1 and 2 for each of the problem areas listed.	
Question 1 What are the youth's needs/problems/symptoms and what current changes have occurred to require the requested level of care?	**Question 2** Clinical treatments and social programs previously used to address each of the problem areas and outcomes achieved, including successful treatment and interventions:
a) Emotional:	**a) Emotional:**
b) Medical, Dental and Vision:	**b) Medical, Dental and Vision:**
c) Family :	**c) Family:**
d) Substance Use Disorder:	**d) Substance Use Disorder:**
e) Peer/Social:	**e) Peer/Social:**
f) Educational:	**f) Educational :**

g) Legal:	**g) Legal:**
h) Trauma History (abuse, neglect, traumatic experiences)**:**	**h) Trauma History** (abuse, neglect, traumatic experiences)**:**

Question 3: Please list the youth's current diagnosis:

Question 4: Development: (milestones, IQ, history of developmental delays, or early intervention services):

Question 5: Please explain why the youth's needs cannot be met in a less intensive level of care:

Question 6: List all current medications, including medical and psychiatric, including dosage:

- Date of last medication evaluation:
- Has this youth been medication compliant? ☐ Yes ☐ No

Question 7: What treatment goals require this level of care and can reasonably be expected to be met?

I have assessed the client and certify that the client meets the ThGH level of care requirements, including: **Initial all three:** ➢ **________ Proper treatment of this client's mental health requires services at this level of care; and** ➢ **________ ThGH treatment interventions can reasonably be expected to improve the patient's condition.** ➢ **_______ A less restrictive treatment intervention does not meet the needs of this client;**
▼ **Psychiatrist or licensed Psychologist's Signature:** ________________________ ▼ **Date:** ________________

All treating clinicians must sign a <u>Treating Clinician Statement</u> (page 5) and Parent/Guardian must sign <u>Permission for Treatment</u> (page 6).

Treating Clinician Statement

Any and all providers treating the member within the last 30 days must review and comment to ensure appropriate coordination of care.

I am aware that an application for Therapeutic Group Home (ThGH) has been submitted for ____ .

(Client's Name)

Please check the appropriate box and sign:

I have reviewed the medical necessity criteria for admission to this level of care and the records of this patient. Based on those guidelines and my knowledge of ____ , it is my professional opinion that:

(Client's Name)

☐ The level of care requested is necessary to meet the patient's need OR

☐ The level of care requested is NOT medically necessary or appropriate. Please describe how you think the patient's needs could be met in a different setting:

▼Treating Clinician's Signature:	▼Date client was last seen:	▼ Date:

If you have any questions, please call Magellan at (800) 424-0333.

Parent/Guardian Permission for Treatment

If you have any questions, please call Magellan at (800) 424-0333.

I am aware that an application for Therapeutic Group Home (ThGH) has been submitted for ________________________________ .

(Client's Name)

**Legal guardian will be responsible for room and board costs associated with authorization at this level of care.

Parent or Guardian must sign below:

PLEASE CHECK ONE:

☐ **As a Parent/Family Member, I understand and commit to my participation in family therapy as part of my child's treatment.**

☐ **As a Parent or Guardian, I cannot commit to participation in family therapy, but designate ______________________(NAME), who is ______________________ (RELATIONSHIP) to participate in family therapy. By signing below, I confirm I have informed the designee of their expected participation in family therapy and they agree to participate.**

<u>For Parents and Guardians:</u>

☐ **As Parent/Guardian, I agree with the need for this level of care and authorize a bed search which allows Magellan to share current and relevant clinical information with any Magellan provider who is credentialed to provide this specific medically necessary treatment.**

☐ **As Parent/Guardian, I believe the level of care requested is NOT necessary or appropriate. Please comment:**

▼Parent/Guardian Signature:	Relationship to the Member:	▼ Date: