Application for Residential Treatment Center Placement
(Must be completed by family)

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

AUTHORITY: 10 U.S.C. Chapter 55; 38 U.S.C. Chapter 17; 32 CFR Part 199; 45 CFR Parts 160 and 164, Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules; and E.O. 9397 (SSN), as amended.

PURPOSE: To obtain information from individuals necessary for their enrollment in TRICARE Programs including managing enrollment through web-based tools, assisting individuals in obtaining authorizations, eligibility determinations, healthcare provider referrals, and customer services, and facilitating medical management, provider services, and payment activities.

ROUTINE USES: In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, these records may be specifically disclosed outside the Department of Defense as a routine use under 5 U.S.C. 552a(b)(3) as follows: to the Departments of Health and Human Services and Homeland Security, and to other Federal, State, local and foreign government agencies, private business entities under contract with the Department of Defense, and individual providers of care, on matters relating to eligibility, claims pricing and payment, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation.

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 outpatient intensive 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.

Services must be provided by a KēPRO℠ certified RTC for children/adolescents. A current listing is available on the KēPRO website: http://tricare.kepro.com. Choose the Mental Health Facilities tab, go to the right side and click on the Facility Listing Report. Choose the most recent month. This report has a listing of all certified RTCs by state.

For questions on the RTC benefit, help locating KēPRO certified facilities or assistance completing this form please contact 1-877-TRICARE (1-877-874-2273). Submit this application and all supporting documentation to 1-877-809-8667.

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 RTC. If you live less than 250 miles from the residential treatment facility, you are expected to be on site 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 on site 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. It is expected GDFT 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.

Signature Parent/Guardian _____Date_____

Signature Parent/Guardian _____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, etc.)

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

Involvement of other agencies for child:

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 (e.g., Medicaid)

TREATMENT WITHIN THE LAST 12 MONTHS

Specify Type of Service: Inpatient; Partial Hospitalization; Residential Treatment Center; Outpatient Individual, Group and/or Family Therapies

Type Service (Inpatient, Outpatient Providers and Residential)	**Name Provider/Facility**	**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)