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|  | | MISSOURI DEPARTMENT OF SOCIAL SERVICES  CHILDREN’S DIVISION  **RESIDENTIAL EXTENDED STAY REVIEW FORM** | | | | | | | |  | | |  | |
| Date of Referral: | |
| Case Manager Name | | | CM’s Telephone # | | | | | Supervisor Name | | | | | | Supervisor Phone # |
| Case Manager County | | | Circuit | | | | |  | | | | | | |
| **Child’s Identifying Information** | | | | | | | | | | | | | | |
| Child’s Name (Last, First, Middle) | | | | DCN | DOB | | | | Gender | | Identified Gender | JU # | | |
| Current Placement | | | | Date of Placement | | | Is Current Placement a QRTP  Yes  No | | | | | | | |
| **Required Documentation (must be attached):** | | | | | | | | | | | | | | |
| Current Court Order  Most recent Social Service Plan  Most recent progress reports (previous 90 days)  Current CD-265  Current CD-275  Current Treatment Plan from Current Placement  Original Independent Assessor Report  Recent Recommendation from Center for Excellence (if applicable) | | | | | | | | | | | | | | |
| **Facility Placement History (Current LS-1 Episode)** Attach additional sheets if necessary. | | | | | | | | | | | | | | |
| Placement | | | | Dates of Placement | | | Was Placement in a QRTP  Yes  No | | | | | | | |
| Placement | | | | Dates of Placement | | | Was Placement in a QRTP  Yes  No | | | | | | | |
| Placement | | | | Dates of Placement | | | Was Placement in a QRTP  Yes  No | | | | | | | |
| Placement | | | | Dates of Placement | | | Was Placement in a QRTP  Yes  No | | | | | | | |
| **Reason for Referral** – This is the reason listed on the original Residential & Specialized Placement Referral (CS-9). | | | | | | | | | | | | | |
| **What is the current case goal:**  Reunification  Guardianship with  Adoption with  APPLA  Placement with Fit and Willing Relative with | | | | | | **What is the current concurrent goal:**  Reunification  Guardianship with  Adoption with  APPLA  Placement with Fit and Willing Relative with  Not Applicable | | | | | | | | |
| **Date of FST:** **Recommendations from team regarding continued residential treatment** *What did the youth’s family and permanency team discuss regarding current treatment plan, progress of this plan, discharge plan, and progress towards discharge? What is the decision of the team regarding ongoing residential treatment?***:** | | | | | | | | | | | | | | |
| **Regional Approver Signature** | | | | | | | | | | | | **Date** | | |
| **Director or Designee Signature** | | | | | | | | | | | | **Date** | | |