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| MISSOURI DEPARTMENT OF SOCIAL SERVICES CHILDREN’S DIVISION**Initial Referral Meeting** |
| **Meeting Date:** |       |  **Request Date:** |       |
| **Worker:**  |       |  **Supervisor:**  |       |
| **Child’s Name:**  |       | **DCN:**  |       |  **DOB:** |       |
| **Family name:**  |       |
| **Phone Number:**  |       |  **Email Address:** |       |
| **Family Address:**  |       |
| **1. Meeting Participants:** (Include names and contact information for attendees) |
|  **Name**  | **Relationship/Role** | **Contact Information** |
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| **2. Reason for request:** (list specific behaviors that have occurred within the last 30 days) |
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| **3. Social Summary:** (include current and past services the family has engaged in) |
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| **4. Referral Discussion:** (discuss all available community services and whether or not they are appropriate to meet the child’s needs) |
| * Community Services Referrals
* Individual/Family Counseling
* Medication Management
* DMH Regional Office Services (DD)
* Drug and Alcohol Treatment
* School (Special Services)
* Juvenile Office
* Hospitalization
 | * Children’s Division Referrals
* Intensive-In-Home Services
* Behavioral Intervention
* Elevated Needs Services/Placement
* Family Centered Services
* Respite
* Other:
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| **5. Subsidized Residential Treatment Eligibility and Approvals**  |
| Subsidy may only pay for residential treatment when all of the following criteria is met: * + The care and treatment of the child out of the home in a residential facility is the least restrictive setting and the program is necessary and appropriate to meet the child’s needs.
	+ The child has been accepted for treatment by a residential facility that is licensed by the state to provide the treatment and the facility is either:
	+ An enrolled MO HealthNet provider; or
	+ An enrolled provider of the Medicaid program in which the state is located; or
	+ A facility contracted with the State of Missouri for payment for the services.
	+ The residential treatment facility is the closest available facility to the child’s home that provides the array of services necessary for the child.
	+ The child has received an approved prior authorization for treatment in the identified residential treatment facility, OR a prior authorization waiver has been approved.
	+ The child has a current, written plan of care.
	+ The adoptive parent(s)/guardian(s) are actively engaged and fulfilling their legal responsibility to the child.

The following documentation must be completed/obtained by the parent(s)/guardian(s) to determine eligibility: * + Residential Treatment Referral, CS-9
	+ An assessment of the child by a licensed and qualified health care professional using the most recent version of the Daily Living Activities (DLA-20) assessment process and tool
	+ The Documentation of any relevant psychiatric/behavioral health diagnosis, and the child’s most recent psychiatric evaluation (completed by a psychiatric, psychologist, or advanced practice nurses), if available.

 **The parent(s)/guardian(s) have been provided with the Adoption and Guardianship Subsidy Residential Treatment flyer which includes:*** **A summary of Subsidized Residential Treatment services**
* **A list of licensed residential treatment providers**
* **Parent/Guardian Rights and Responsibilities**
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| **6. Next Steps:** (list each task, who is responsible, and when it will be completed by) |
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