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| MISSOURI DEPARTMENT OF SOCIAL SERVICES  CHILDREN’S DIVISION  Continuing Stay Review | | | | | | | |
| **Meeting Date:** |  | | | | **Waiver End Date:** | |  |
| **Worker:** |  | | | | **Supervisor:** | |  |
| **Child’s Name:** |  | | | | **DCN:** |  | **DOB:** |
| **Family Name:** |  | | | | | | |
| **Phone Number:** |  | | | | **Email Address:** | |  |
| **Family Address:** |  | | | | | | |
| **Residential Facility** |  | | | | | | Non-QRTP  QRTP  PRTF  Child Specific Contract  Aftercare |
| **Facility Address** |  | | | | | |
| **1. Meeting Participants:** (Include names and contact information for attendees.) | | | | | | | |
| **Name** | | **Relationship/Role** | | | **Contact Information** | | |
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| **2. Required Documentation:** (Items listed with an asterisk (\*) are mandatory): | | | | | | | |
| * The child’s plan of care\* * Treatment progress notes\* * Family therapy progress notes, or documentation why this is not occurring or is excused\* * Updates to the child’s diagnoses and prognosis\* * Medications prescribed to the child, including any changes to medications\* * A Discharge plan (outpatient providers, appointments, and recommended level of care)\* * A new DLA-20, or equivalent assessment of whether treatment in a residential setting is necessary by a clinician trained and qualified to perform the assessment. | | | | | | | |
| **3. Plan of Care:** (Summarize the child’s plan of care, diagnosis, medications, goals that have been set, time limits given, how goals were or were not attained and if any changes are necessary.) | | | | | | | |
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| **4. Family Engagement:** (Summarize the efforts by the family to participate in the child’s care, treatment, and discharge plan. Information should include, but is not limited to, family therapy progress, or detailed documentation to establish whether family therapy sessions are not occurring or have been excused.) | | | | | | | |
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| **5. Discharge Plan:** (Include any details currently available including any established outpatient providers, appointment dates and times, recommended treatment level of care.) | | | | | | | |
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| **8. Recommendation:** (include date/time for the next continuing stay review meeting)  1. Continuation of subsidized residential treatment services  Length of care not to exceed six months:  Level of care:  2. Discontinuation of subsidized residential treatment services  **Explanation:** | | | | | | | |
| **Parent/Guardian** | **Agree** | | **Disagree** | **Explanation of disagreement** | | | | |
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