PerformCARE®

OUT-OF-HOME TIER II CONSULTATION REQUEST FORM

Qualifying Criteria:

Case Management Entities (CME), (CMO, DD Consultants, or DCP&P) may submit a Tier II Consultation Request Form to PerformCare if the out-of-home referral meets one of the following Intensities of Service IOS (check-off applicable IOS):

- ☐ Treatment Home **(TH)**
- ☐ Group Home **(GH)**
- ☐ Residential Treatment Center **(RTC)**
- ☐ I/DD **(SSH, GH)**

Referrals that are identified as Specialty (SPEC), Psychiatric Community Home (PCH), or if the youth is pregnant, a referral should be immediately sent to the Children's System of Care (CSOC) Specialized Residential Treatment Unit (SRTU) for consultation.

The youth's out-of-home referral must meet <u>at least</u> one (1) of the following criteria (check-off applicable criteria):

☐ At least three (3) providers at the youth's identified Intensity of Service (IOS) documented "Not Accept" in Youth Link:

- All referrals identified as "Not Accept" must be from identified IOS via OOH Referral Request or Transitional Joint Care Review (TJCR);
- All "Not Accept" referrals must be documented in Youth Link which includes description of denial reason;
- "Not Accept" referrals that are not documented in Youth Link do not count; in the event a referral denial is not documented in the system, CME should contact the OOH provider to assure that documentation is properly entered in CYBER;

☐ Youth's out-of-home referral has been on Youth Link for 30+ days and placement has not been secured.

PerformCare staff will not review referrals that do not meet at least one of the above-mentioned criteria.

IDENTIFYING INFORMATION

CASE MANAGER NAME:

CM SUPERVISOR NAME:

CASE MANAGEMENT ENTITY:

PHONE #:

E-MAIL ADDRESS:

YOUTH'S NAME:

CYBER ID#:

REFERRAL #:

YOUTH'S CURRENT LOCATION:

 # OF DAYS ON YOUTH LINK:

REFERRAL DENIALS

#	IOS	AGENCY/SITE NAME	DENIAL REASON
1.			
2.			
3.			
4.			
5.			
6.			

REFERRAL INFORMATION

IS REFERRAL ACTIVE ON YOUTH LINK?	☐ **YES**	☐ **NO**	
IS YOUTH PREGNANT?	☐ **YES**	☐ **NO**	☐ **N/A**
DDD ELIGIBLE?	☐ **YES**	☐ **NO**	☐ **PENDING**
ED CLASSIFIED?	☐ **YES**	☐ **NO**	☐ **PENDING**
DIABETIC NEEDS?	☐ **YES**	☐ **NO**	
SPECIAL MEDICAL NEEDS?	☐ **YES**	☐ **NO**	

Describe medical needs: _____

_____

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_____

Has there been any new clinical documentation since the initial IOS determination?

☐ **YES** ☐ **NO**

Provider clinical information (include evaluation type, name/credential of evaluator, date of evaluation, diagnosis (if available) and recommendations for treatment:

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Describe any other placement barriers:_____

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Other information:_____

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TIER II REVIEW RECOMMENDATIONS (PerformCare use only)

Date of Recommendations: _____

Name of Reviewer: _____

Reviewer Recommendations:_____

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Recommendations will also be documented in CYBER Progress Notes