Aetna Better Health® of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

Children's Residential Request Form

Fax to: **1-866-366-7008** Telephone: **1-844-835-4930**

A determination will be communicated to the requesting provider

- **Please complete all fields, incomplete requests will delay the prior authorization process**
- Please include pertinent chart notes to expedite this request

Type of Request

☐ **Initial Request**
☐ **Continued Stay Request**
Court Ordered ☐ **Yes** ☐ **No**

PATIENT INFORMATION					
Patient Name: Last	First	MI	Date of Birth:	Age:	
I.D. #:	Gender: ☐M ☐F	Other Insurance? ☐YES ☐NO	Name of Carrier:		
FROM: REQUESTING PROVIDER					
Requesting Provider (Please Print):			**NPI #:**		
Contact Person in Requesting Provider's Office:	Telephone:		Fax:	**Tax ID #:**	
Clinical Contact Person:	Telephone:		Name of PCP:		
TO: WHERE WILL PATIENT RECEIVE SERVICES?					
Physician/Provider/Facility Requested:	Address:		Telephone:	Fax:	
Where services will be rendered? (Provide name of facility, if other than provider office or patient's home)					
Today's Date:	Tentative Date of Service/Admission:		Start Date: End Date:		
CLINICAL INFORMATION					
ICD -10 Codes: (required) 1) 2) 3) 4)			ICD-10 Description:		
☐	Level I – H0019U1				
☐	Level II – H0019U2		Level of Functional Impairment: ☐Mild ☐Moderate ☐Severe		
☐	Level III – H0019U3		Is this a stepdown? ☐ Yes ☐ No		
☐	Level IV – H0019U4		Dates of previous admission:		
Number of requested days:			Previous Admitting Facility:		

CLINICAL INDICATIONS/RATIONALE FOR REQUEST:
To expedite a determination on your request for services, please attach clinical documentation/medical records to support your request. Please include the following: Conservative treatment tried and failed, applicable diagnostic testing with results and lab values and a medication list if available.

INITIAL REQUEST LEVELS I-III Select all that apply	
☐	The Child's age range is from eight years of age through age 17 unless the provider has a specific contract or has received a waiver from the BCF to service a child who does not meet the age requirements, and
☐	The child has a behavioral health diagnosis that meets medically necessity for Residential Children's Services at the level selected above, and
☐	The child demonstrates level of appropriate symptoms or functional impairment which interfere with age appropriate adaptive and psychological functioning and social problem solving that prohibit a relationship with a family, or whose family situation and functioning are such that the child cannot accept family ties or establish relationships in a less restrictive setting, and
At least one must be met below	
☐	The child's symptoms and functional impairment are such that the treatment team needs are best met in a community-based structured setting where the client can remain involved in the community, school and recreational activities, and cannot be successfully provided in a less intensive level of care. (Level I)
☐	The child's symptoms or functional impairments are such that the treatment cannot be successfully provided in a less intensive level of care, and The child's symptoms or functional impairments have existed for duration of six months or longer, and are part of an established and persistent pattern of disruptive behavior at home, in school, or in the community. (Level II)
☐	The child's symptoms or functional impairments have existed for a duration of one year or longer, and are part of an established and persistent pattern of disruptive behavior at home, in school, or in the community. (Level III)

Please provide information that supports above information or attach clinical:
Initial Requests
What is the reason the patient is being referred or brought to program?
Who is their guardian?
If applicable, any Psych Testing completed and if so, what is IQ?
Previous attempts at treatment including have they utilized wrap around services?
Recent behaviors:
Education/School:
Treatment Plan / Progress toward goals:
Participation in therapy, groups, family meetings etc.:
Family involvement (home passes, family meetings, onsite visits, community passes):

Physical Health Needs:

EPSDT Services:

☐ Comprehensive Physical Exam
☐ Mental Health Screening
☐ Immunizations
☐ Laboratory Tests
☐ Vision Screening
☐ Oral Health Screening
☐ Vision Services
☐ Dental Services
☐ Hearing Services
☐ Hearing Screening

Provider Services:

PCP Provider Name: Date of Service:

BH Provider Name: Date of Service:

Medication changes:

Anticipated Discharge Date:

Anticipated Discharge Disposition and Followup:

Date of Current CAFAS (within the last 30 days for initial and 90 days for continued stay from the request date)

CAFAS score:

Date of current CANS (within the last 30 days from the request date)

☐Attached

CSED Waiver Application

☐YES Date of application:

☐NO

If no, CSED Waiver Application, please explain why:

INITIAL REQUEST LEVEL IV **Select all that apply**	
☐	The child's age range is from eight years of age through age 17 unless the provider has a specific contract or has received a waiver from the BCF to serve a child who does not meet the age requirements, and
☐	The child is experiencing a crisis due to a mental condition or impairment in functioning due to a problematic family setting. The child may be displaying behaviors and/or impairments ranging from impaired abilities in the social, communication, or daily living skills domains to severe disturbances in conduct and emotion. The crisis results in emotional instability which may be caused by family dysfunction, transient situation disturbance, physical or emotional abuse, neglect, sexual abuse, loss of family or other support system, or the abrupt removal of the child from a failed placement or other current living situation, **and**
At least one must be met below	
☐	The child is in need of 24-hour treatment intervention because less restrictive services alone are not adequate or appropriate to resolve the current crisis and meet the child's needs based on the documented response to prior treatment and/or intervention, or
☐	The child is in need of 24-hour treatment/intervention to prevent hospitalization (e.g., the child engages in self-injurious behavior, but not at a level of severity that would require psychiatric hospitalization, or the child is currently physically aggressive and communicates verbal threats, but not at a level that would require hospitalization), or
☐	The child is in need of step-down from a more restrictive level of care as part of a transitional discharge plan (e.g., behaviors/symptoms remain at a level which requires out of home care, but the placement plan has not been fully implemented.)
Please provide information that supports above information or attach clinical:	

CONTINUING STAY CRITERIA Level I-III Select all that apply	
☐	The child is under the age of 18 or 22 if the youth is in the West Virginia Department of Health and Human Resources' (DHHR) custody, and
☐	They continued stay is not used solely for providing special education, housing, supervision, or meeting other needs that are not medically necessary, and the child continues to exhibit symptoms and/or functional impairment such that treatment needs are best met in a community-based setting where the child can remain involved in the community, school and recreation activities, or
☐	The child has not completed the goals and objectives of the service plan which are critical to warrant transition to a less intensive level of service, or
☐	The child has not demonstrated any progress toward treatment goals, but the service plan has been modified to introduce further evaluation in order to clarify the nature of identified problems and/or new therapeutic interventions have been initiated, or
☐	The child demonstrates new symptoms or functional impairment in adaptive and/or psychological functioning, and problem solving, which met the criteria for admission, or
☐	The child's symptoms have diminished, and functional impairment has improved, but there are continuing symptoms and functional impairment in the child's adaptive and/or psychological functioning or social problem solving, and/or due to significant disruptions in the biological or adoptive family interactions, or
☐	The child demonstrates an inability to sustain gains without the therapeutic service provided by the Residential Children's Services program.
CONTINUING STAY CRITERIA Level IV Select all that apply	
☐	The child is under the age of 18 or 22 if the youth is in DHHR custody, and
☐	Symptoms, behaviors, or conditions persist at the level documented upon admission and the projected time frame for accessing long-term placement has not been reached, or
☐	Relevant member and family progress toward crisis resolution and progress clearly and directly related to resolving the factors that warranted admission to this level of care have been observed and documented, but treatment goals have not been reached and/or an appropriate level of care is not available, or
☐	It has been documented that the member has made no progress toward treatment goals nor has progress been made toward alternative placement, but the treatment/placement plan has been modified to introduce further evaluation of the member's needs and other appropriate interventions and placement options, or
☐	New symptoms or maladaptive behaviors have appeared which have been incorporated into the service plan and modified the service plan for the member, or
☐	These new symptoms and maladaptive behaviors may be treated safely in the short-term residential setting and a less intensive level of care would not adequately meet the child's needs.
Please provide information that supports above information or attach clinical:	

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