

Therapeutic Group Home Application (ThGH)



Please submit this application and all supporting documentation to:

Magellan Behavioral Health
 ATTN: Residential Psychiatric Applications
 1221 N Street, Suite 325, Lincoln, NE 68508
 Phone (800) 424-0333 ~ Fax (866) 848-4942

**The completed application must be sent via fax or postal mail.
 For security reasons, emailed applications will not be accepted.**

Clinical Contact Information:	* * * * Attachments * * * *
MIS#	THE FOLLOWING DOCUMENTATION MUST ACCOMPANY THE APPLICATION:
Name:	
Address:	
City/State/Zip:	
Phone #:	
Fax #:	
Client Information:	
Name:	
Date of Birth:	
Medicaid #:	
Legal Guardian Name: If Client is State Ward, HHS Case Manager Name:	<input type="checkbox"/> Initial diagnostic interview
Legal Guardian Address:	<input type="checkbox"/> Assessment completed by the Psychiatrist or Licensed Psychologist including: Patient's history of problems and attempted treatment efforts, recommendations of issues to be addressed during ThGH treatment, and recommendation for ThGH level of care. (if available)
Legal Guardian City, State, Zip:	<input type="checkbox"/> Educational records (most recent IEP and psycho-educational testing, etc.)
Legal Guardian Phone #:	<input type="checkbox"/> Discharge summaries from previous inpatient and outpatient treatment (if applicable)
Youth Current Residence / Placement:	<input type="checkbox"/> If requesting sex-offender specific treatment, a current sex offender risk assessment
State Ward? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> If requesting dual (MH/SA) or SA only treatment, a current substance use Disorder evaluation (including ASAM)
Please indicate if specific treatment is requested for one of the following: <input type="checkbox"/> Mental Health Only <input type="checkbox"/> Sexual Offender <input type="checkbox"/> Mental Health/Substance Use Disorder (Dual)	<input type="checkbox"/> Child and Adolescent Needs and Strengths (CANS) assessment (if available)
Lead Agency Involvement? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Most recent other psychological evaluations (if available)
If yes , please provide: Lead Agency: Care Coordinator Name: Care Coordinator Phone #:	<input type="checkbox"/> Treating Clinician Statement from all active MH/SA Providers
	<input type="checkbox"/> Parent/Guardian Permission for Treatment
	Probation Involvement? <input type="checkbox"/> Yes <input type="checkbox"/> No
	If yes , please provide: Probation Officer's Name: Probation Officer's Phone #:

Answer questions 1 and 2 for each of the problem areas listed.

Question 1 What are the youth's needs/problems/symptoms and what current changes have occurred to require the requested level of care?	Question 2 Clinical treatments and social programs previously used to address each of the problem areas and outcomes achieved, including successful treatment and interventions:
a) Emotional:	a) Emotional:
b) Medical, Dental and Vision:	b) Medical, Dental and Vision:
c) Family :	c) Family:
d) Substance Use Disorder:	d) Substance Use Disorder:
e) Peer/Social:	e) Peer/Social:
f) Educational:	f) Educational :

g) Legal:	g) Legal:
h) Trauma History (abuse, neglect, traumatic experiences):	h) Trauma History (abuse, neglect, traumatic experiences):
Question 3: Please list the youth's current diagnosis:	
Question 4: Development: (milestones, IQ, history of developmental delays, or early intervention services):	
Question 5: Please explain why the youth's needs cannot be met in a less intensive level of care:	
Question 6: List all current medications, including medical and psychiatric, including dosage: <ul style="list-style-type: none"> • Date of last medication evaluation: • Has this youth been medication compliant? <input type="checkbox"/> Yes <input type="checkbox"/> No 	
Question 7: What treatment goals require this level of care and can reasonably be expected to be met?	

I have assessed the client and certify that the client meets the ThGH level of care requirements, including:

Initial
all
three:

- _____ Proper treatment of this client's mental health requires services at this level of care; and
- _____ ThGH treatment interventions can reasonably be expected to improve the patient's condition.
- _____ A less restrictive treatment intervention does not meet the needs of this client;

▼ Psychiatrist or licensed Psychologist's Signature:

▼ Date:

All treating clinicians must sign a Treating Clinician Statement (page 5) and Parent/Guardian must sign Permission for Treatment (page 6).

Treating Clinician Statement

Any and all providers treating the member within the last 30 days must review and comment to ensure appropriate coordination of care.

I am aware that an application for Therapeutic Group Home (ThGH) has been submitted for _____ .
(Client's Name)

Please check the appropriate box and sign:

I have reviewed the medical necessity criteria for admission to this level of care and the records of this patient. Based on those guidelines and my knowledge of _____ , it is my professional opinion that:

(Client's Name)

- The level of care requested is necessary to meet the patient's need OR
- The level of care requested is NOT medically necessary or appropriate. Please describe how you think the patient's needs could be met in a different setting:

▼Treating Clinician's Signature:	▼Date client was last seen:	▼ Date:

If you have any questions, please call Magellan at (800) 424-0333.

Parent/Guardian Permission for Treatment

If you have any questions, please call Magellan at (800) 424-0333.

I am aware that an application for Therapeutic Group Home (ThGH) has been submitted for _____
(Client's Name)

**Legal guardian will be responsible for room and board costs associated with authorization at this level of care.

Parent or Guardian must sign below:

PLEASE CHECK ONE:

- As a Parent/Family Member, I understand and commit to my participation in family therapy as part of my child's treatment.
- As a Parent or Guardian, I cannot commit to participation in family therapy, but designate _____ (NAME), who is _____ (RELATIONSHIP) to participate in family therapy. By signing below, I confirm I have informed the designee of their expected participation in family therapy and they agree to participate.

For Parents and Guardians:

- As Parent/Guardian, I agree with the need for this level of care and authorize a bed search which allows Magellan to share current and relevant clinical information with any Magellan provider who is credentialed to provide this specific medically necessary treatment.
- As Parent/Guardian, I believe the level of care requested is NOT necessary or appropriate. Please comment:

--	--	--

▼ Parent/Guardian Signature:	Relationship to the Member:	▼ Date: