



Residential Treatment Center (RTC) Application



Patient's Name:		Sponsor SSN:
DOB:	Age:	Date of Application:
Patient Address:		
City:	State:	Zip:
Name of Parent/Legal Guardian:		
Telephone:		
Other Insurance: <input type="checkbox"/> Yes* <input type="checkbox"/> No		
*If yes, please specify:		
Patient's current placement:		
<input type="checkbox"/> Home	<input type="checkbox"/> Other family	<input type="checkbox"/> Hospital <input type="checkbox"/> Foster Setting <input type="checkbox"/> Juvenile Detention

RTC APPLICATION INSTRUCTIONS

This application must be completed and **signed** by the current treating Physician or Clinical Psychologist who is recommending treatment in an RTC. Information must be current and based on recent contact with the patient and family.

Note: Parent/guardian(s) may want to duplicate all of these materials since much of the same information will be required by the facility for which the applicant is being considered.

RECOMMENDED DOCUMENTATION

To assist in determining medical necessity for residential treatment placement it is **strongly recommended** that the following clinical documentation be provided as available/applicable:

- Family/Social History
- Psychological/Physical, Neurological Assessment, Evaluation and Testing Results
- Educational Assessment with Levels of Academic Achievement
- Psychiatric Evaluations, Discharge Summaries, Clinical from Previous Inpatient Psychiatric admissions

*****Failure to submit appropriate documentation could result in an adverse decision. *****

DSM IV Diagnosis (Please complete all fields below):
Axis I:
Axis II:
Axis III:

