Psychiatric Residential Treatment Facility (PRTF) Eligibility for Admission

A licensed mental health professional must sign and date this form. This form is used to determine PRTF eligibility only.

Attach this completed form, along with other supporting documentation, to a Service Authorization>Medical Services request created in the PrimeWest Health provider web portal using the PRTF template.

If you are not already registered for the provider web portal, you can request access on our website.

Submission of this form does not guarantee approval.

Forms submitted with incomplete data cannot be reviewed and will be returned to your office. Call the PrimeWest Health Provider Contact Center at **1-866-431-0802** (toll free) with questions.

Member Information

LAST NAME	FIRST NAME	MI	DATE OF BIRTH	MEMBER ID
PARENT OR GUARDIAN NAME(S)	STREET ADDRESS			
CITY	STATE	ZIP CODE		
ADDITIONAL GUARDIAN NAME(S)	STREET ADDRESS			
CITY	STATE	ZIP CODE		

Requesting Provider Information

NAME OF MENTAL HEALTH PROFESSIONAL	LICENSE (LPCC, LICSW, etc.)	NPI NUMBER
AGENCY NAME	RELATIONSHIP TO MEMBER (psychiatrist, therapist, etc.)	
STREET ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	EMAIL ADDRESS	

Reason for Referral

DATE OF MOST RECENT DIAGNOSTIC ASSESSMENT	DIAGNOSTIC ASSESSMENT COMPLETED BY
PRIMARY DIAGNOSIS (Must include the most current ICD code)	DESCRIPTION
SECONDARY DIAGNOSIS (Must include the most current ICD code)	DESCRIPTION
ADDITIONAL DIAGNOSES REQUIRING TREATMENT (Must include the most current ICD code)	DESCRIPTION
BEHAVIORAL OR PSYCHIATRIC SYMPTOMS REQUIRING TREATMENT (Describe)	
DESCRIBE HISTORY OF TRAUMA (If known)	
SEVERE, CHRONIC, AND FREQUENT AGGRESSION OR DANGER TO SELF OR OTHERS (Describe)	
FUNCTIONAL IMPAIRMENT (Unable to maintain behavioral control, frequent interpersonal conflict, unable to appropriately engage in activities of daily living) (Describe)	
EXACERBATING SYMPTOMS, INCLUDING HISTORY OF ONSET OF ALL SYMPTOMS (Describe)	
CURRENT MEDICATIONS (List name, dosage and condition treated)	

Other Community-Based Services (check all that apply)

MENTAL HEALTH SERVICE	DATES OF SERVICE & FREQUENCY	DESCRIBE SERVICE	PROVIDER
☐ INDIVIDUAL PSYCHOTHERAPY			
☐ FAMILY PSYCHOTHERAPY			
☐ GROUP PSYCHOTHERAPY			
☐ SCHOOL MENTAL HEALTH SERVICES			
☐ CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS (CTSS)			
☐ PARTIAL HOSPITALIZATION PROGRAM (PHP)			
☐ INTENSIVE OUTPATIENT PROGRAM (IOP)			
☐ CHILDREN'S MENTAL HEALTH TARGETED CASE MANAGEMENT (CMH-TCM)			
☐ INTENSIVE TREATMENT IN FOSTER CARE (ITFC)			
☐ DAY TREATMENT			
☐ PERSONAL CARE ASSISTANT (PCA)			
☐ WAIVER SERVICES (CADI or DD)			
☐ NEUROPSYCHOLOGICAL OR PSYCHOLOGICAL EVALUATION			
☐ CRISIS SERVICES			
☐ PSYCHIATRY/MEDICATION MANAGEMENT			
☐ SUBSTANCE USE DISORDER (SUD) SERVICES			
☐ OTHER (Describe)			

History of Hospitalizations or Residential Treatment (More information can be added on Page 5)

NAME OF FACILITY	DATES OF ADMISSION AND DISCHARGE	REASON(S) FOR ADMISSION

SOCIAL SERVICES	AGENCY OR COUNTY	DATES OF SERVICE	BRIEFLY DESCRIBE REASON FOR INVOLVEMENT
☐ CHILD WELFARE			
☐ JUVENILE JUSTICE INVOLVEMENT			
☐ OTHER (Describe)			

Educational Information

SCHOOL DISTRICT	CURRENT 504 OR IEP?	SPECIAL EDUCATION QUALIFICATION CATEGORY? (List all that apply)	DESCRIBE SCHOOL FUNCTIONING AND EDUCATIONAL PLACEMENT
	○ 504 ○ IEP		

Supporting Documentation Checklist

☐ This form (signed by licensed mental health professional)

☐ Diagnostic assessment (DA) or similar document (*see requirements)
*DA requirements: A DA or similar document that has been completed within the past 180 days must accompany this form. Acceptable alternatives to a DA include a psychiatric or psychological evaluation completed by a licensed psychologist or medical doctor. The psychiatric or psychological evaluation may be accepted as long as all the elements of a standard DA are met. DA must include most recent functional assessments including substance abuse screens where applicable. Please note that other clinically relevant information may be requested by the review team.

☐ Parent or guardian(s) has consented to referral and psychiatric residential treatment facility treatment

☐ If PRTF has been identified, please list here: _____

Check if signing electronically:

☐ I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (MN Stat. sec. 325L.02[h], 325L.05, and 325L.08)

MENTAL HEALTH PROFESSIONAL SIGNATURE	DATE

County Notification to PrimeWest Health

If the member is connected to their county by targeted case management or other case management services, the county representative must notify PrimeWest Health's Behavioral Health team of any pending placement in a PRTF via email to behavioralhealth@primewest.org.

The email must include the member's name, PMI number, name of the provider(s) being considered for placement, and the placement date if it is known. This notification does not serve as authorization for placement. The Behavioral Health team will send a reply email confirming receipt of notification only.

Additional History of Hospitalizations or Residential Treatment

NAME OF FACILITY	DATES OF ADMISSION AND DISCHARGE	REASON(S) FOR ADMISSION