

**ATTACHMENT 8**  
**PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE**

**Community Based Mental Health Services - Alternatives**  
**to Residential Mental Health Treatment Services**

CASSP principles for services for children and adolescents in Pennsylvania guide the decision making process regarding referral of children and adolescents with mental illness or severe emotional disturbance to residential services. Specifically placement in residential treatment settings should be guided by the following:

- a. The family setting should be the first focus for treatment for the child or adolescent. Out-of-home placement or hospitalization should be the last alternative, and
- b. Communities should develop a rich array of services for children and their families so that alternatives to out-of-home placement are available, such as home-based services, parent support groups, day treatment programs, crisis centers, and respite care.

To assist the Department in its prior authorization process for medically necessary mental health residential services, please complete the following:

1. Child's Name: \_\_\_\_\_ BSU # \_\_\_\_\_
2. Have Family Based Mental Health Services and/or Family Preservation Services been utilized? Yes \_\_\_\_\_ No \_\_\_\_\_  
Why are these services not being used?
3. Was a comprehensive, non-residential mental health wraparound services plan developed? Yes \_\_\_\_\_ No \_\_\_\_\_ Describe the plan or the reason for not developing a plan.
4. Was a comprehensive, non-residential mental health wraparound services plan implemented? Yes \_\_\_\_\_ No \_\_\_\_\_ Why did this plan not meet the needs of the child?

5. List other community-based mental health services utilized in the previous 3 to 6 months to prevent an out-of-home placement, and explain why these efforts were unsuccessful.

6. Was an Interagency Service Planning Team Meeting held?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, on what date? \_\_\_\_\_ If not, why not?

a. Name the agencies which were present:

---

---

b. Was the child (as age appropriate) and family representative included? If not, why not?

---

---

c. If the child is enrolled in a managed care program, identify representative included in the team:

---

7. Does the Interagency Service Planning Team recommend approval of a residential placement? Yes \_\_\_\_\_ No \_\_\_\_\_  
If not, why not?

8. What are the specific goals for the child in the residential placement:

---

---

---

---

9. What is the expected length of stay? \_\_\_\_\_

10. What is the educational plan for this child/adolescent? Does the responsible school district recommend residential services? If not, why not?
  
11. Is the child in the custody of the Children & Youth Agency?  
Yes\_\_\_\_\_ No\_\_\_\_\_
  
12. Is the child adjudicated delinquent? Yes\_\_\_\_\_ No\_\_\_\_\_
  
13. Does the County MH/MR Administrator (or designee) recommend approval? Yes\_\_\_\_\_ No\_\_\_\_\_ If not, why not?
  
14. Please list the name, address and telephone number of the primary case manager assigned to support this child and family in their use of and access to the services on the Plan of Care Summary.

Approved: \_\_\_\_\_

County MH/MR Administrator

\_\_\_\_\_  
County C&Y Director or Juvenile  
Probation Director (or designee)  
If Applicable

\_\_\_\_\_  
Name & Title (print)

\_\_\_\_\_  
Name & Title (print)

15. For a re-authorization request, attach the discharge plan for the child.