

Children’s Long-term Inpatient Program (CLIP) Administration Voluntary Application

Dear Parent or System Partner:

You have agreed to complete a voluntary application form to request your child be admitted to a Children’s Long-term Inpatient Program (CLIP). We need the information we ask for to make sure your child currently needs this level of care. We are required to review this type of information by our state and federal funding sources for CLIP.

Some General points to remember while filling out the application:

- Long statements of information are not necessary; clear, simple to the point answers are sufficient.
- Copies will be made of this material, please give us single sided copies without staples whenever possible.
- For most treatment and background information, **the last Two Years of services and functioning is what we will be reviewing.** Most children referred to CLIP have received multiple services through many years, but qualifications for CLIP are largely based on current functioning, current strengths, and services received for the past two years.

Contents

1. Demographics	2
2. Youth Treatment History	3-4
3. Youth and Family Team Members	5
4. Narrative Section of Voluntary Application	6-7
5. Developmental, Family and Cultural History Narrative	8
6. Current Medical Status & Legal Status Narrative	9
7. Educational History Narrative.....	10
8. CLIP Application Materials Checklist	11-12
9. Youth Agreement to CLIP Treatment.....	12
10. Help Guide for CLIP Voluntary Application Form	13-15

DEMOGRAPHICS

Application Date:	Youth's Name:
US Citizen: <input type="checkbox"/> Yes <input type="checkbox"/> No	Birth date:
State youth was born in:	Age:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	Ethnicity:
Height:	Weight:
Does parent agree with the need for CLIP? <input type="checkbox"/> Yes <input type="checkbox"/> No	Adopted: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, State of Adoption:
School District:	IEP or 504 plan: <input type="checkbox"/> Yes <input type="checkbox"/> No
Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No PIC #:	SSI/SSA Benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No Private Insurance Name:
Parent/Guardian Name:	Tel:
Address:	EMAIL :
Does youth have a DCYF caseworker/social worker? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, Name and Office Location of Caseworker/social worker: Tel: EMAIL:
<i>FOR Behavioral Health Organization (BHO)/Managed Care Organization (MCO) OFFICIAL USE ONLY</i>	
Referral Source:	Tel:
Date of local Review:	Youth's County of Origin:
BHO/MCO designee to follow youth while in CLIP:	Tel:

Current Psychotropic Medications:

Name of Treating Psychiatrist or current prescriber:

Inappropriate Sexual Behavior: Yes No
If yes, please describe:

Psychosexual Evaluation completed: Yes No

Youth Treatment History

Psychiatric Hospitalizations:

Facility	Admit Date(s)	Discharge Date(s)
Use boxes below to enter information for 'other' or out of state hospitals		

Department of Children, Youth and Families (DCYF) Services (i.e. foster homes, in-home services, BRS group homes, residential care, Family Reconciliation Services, Family Preservation Services, foster care):

Agency	Admit/Intake Date	Discharge/Termination

Outpatient Mental Health Treatment Episodes (i.e. therapy, crisis services, psychiatric care, WISe)

Agency	Admit/Intake Date	Discharge/Termination

Chemical Dependency Treatment:

Agency	Admit/Intake Date	Discharge/Termination

Youth & Family Team Members

NAME	RELATIONSHIP/ AFFILIATION	PHONE NUMBER	Email Address

How frequently does the team meet?_____

Narrative Section of Voluntary Application Continued

Identify the youth's 3-5 MOST CRITICAL clinical issues that need to be addressed in treatment. Please be specific/detailed.

1.

2.

3.

4.

5.

Please describe the family's 3-5 MOST CRITICAL needs to be addressed in treatment. Please be specific/detailed. (i.e. family therapy, behavior management skills, improved communication, coping skills specific to youth's needs, education/knowledge regarding psychiatric disorders, support to cope with youth's challenges, etc.)

1.

2.

3.

4.

5.

Developmental, Family and Cultural History Narrative

Please provide a *brief narrative* describing the youth's **developmental, family and cultural history**. Information should describe:

- Pregnancy, birth, developmental milestones
- Current living situation
- Name, occupation, marital status and location of natural and/or step-parents, adoptive parents or guardians
- Names and birth dates of siblings
- History of known psychiatric problems in the family
- Cultural background, including any specific practices of the youth and family

(*or reference the *specific* document(s) which provides this information)

Narrative:

Current Medical Status & Legal Status Narrative

Please provide a *brief narrative* describing the youth's current **medical status** including a description of any health issues or medical conditions and known allergies.

(*or reference the *specific* document(s) which provides this information)

Narrative:

Please provide a *brief narrative* describing the youth's current **legal status** including a description of current probationary or parole status, history of diversion, adjudication and incarceration, a description of pending charges and any changes in legal custody.

(*or reference the *specific* document(s) which provides this information)

Narrative:

Educational History Narrative

Please provide a *brief narrative* describing the youth's **educational history** including most recent school attended, whether currently attending, current performance in school and a brief outline of youth's historical performance, and highest grade completed.

(*or reference the *specific* document(s) which provides this information)

Narrative:

CLIP Application Materials Checklist

In addition to the previous pages additional documentation is required to meet the complete application requirements. Please provide the following information in the form of copies of existing documents which contain the required information. You may also choose to prepare an outline of the required material. Please use this document to check off the documents you have attached.

Current Psychiatric Evaluation

A current psychiatric evaluation is required for all referrals. This can be done either through an inpatient or outpatient treatment provider. This must be:

- Completed and signed by a psychiatrist or a psychiatric ARNP (PhD are *not* acceptable)
- Dated within the last 6 months
- Includes a DSM V Diagnostic classification
- Includes at a minimum a Mental Status Exam, and Complete Assessment of Treatment needs of the applicant.

Inpatient Psychiatric Treatment

If youth has been hospitalized please provide the following for **each admission**:

- Admission History and Physical
- Discharge Summary
- Any Special Testing or Evaluations completed

Outpatient Mental Health Treatment and Substance Use Disorder (SUD) Treatment

If youth has received outpatient mental health or chemical dependency services please provide documents which describe the services and treatment provided, outcomes/progress and reason for termination.

- Last 6-months of medication management/Psychiatric notes
- Psychiatric assessments
- Medication history
- Crisis Service Summary
- Chemical Dependency Assessment if applicable

Foster Care, In-home Services and Residential Care

If youth has received in or out of home services please provide the following documents from **each provider**.

- Treatment Reviews (past 6 months)
- Discharge Summaries
- Family Team Decision-making Meeting (FTDM) Notes
- Foster Care Assessment Program (FCAP) Assessments
- Specialized evaluations done within those settings

Department of Child Youth and Family (DCYF)

If a youth has an open case with DCYF please provide:

- Legal and Placement History
- Most recent Court Report
- Dependency Order
- CPS History for the past two years

School

Please provide information regarding the youth’s educational history to include

- Current IEP/504 plan
- Most recent Summary Assessment Review or Reevaluation (this document qualifies youth for Special Education Services, is done every 3 years)

Other Specialized Evaluations

If the youth has received any specialized evaluations please provide these documents. Such evaluations may include:

- Neuropsychological Evaluations
- Psychosexual Evaluations
- IQ Testing
- Fetal Alcohol Evaluations
- Autism Evaluation
- Developmental Disability Evaluations
- Any medical evaluation specific to the youth’s individual issues
- Parenting plan/visitation orders if currently applicable to parent visits/custody situation
- Any Legal contact or visitation restrictions

- You may also include any other pertinent information to overall treatment
- Youth Agreement to CLIP Treatment (*final page, filled out by hand, required for youth ages 13+, optional for youth ages 5-12years*)

If you have any questions regarding the application process please call your local BHO/MCO or the CLIP Coordinator at the CLIP Administration at (206) 420-3559.

Application Completed by:	
Name:	Affiliation/Relationship:
Phone Number:	Email:

Please print and include all pages of this application, sign and date below, and include with the above attached materials.

Signature of BHO/MCO representative: _____ **Date:** _____

Youth Agreement to CLIP Treatment
Required for youth 13-17, optional for youth 5-12

Read:

Your family and community treatment team have recommended you for inpatient treatment at the Children's Long Term Inpatient Program (CLIP).

CLIP is a voluntary residential treatment program for youth ages 5-17 years old. Any youth over the age of 13 years old must agree with the need for treatment and sign in as a voluntary client upon admission.

CLIP treatment is provided in a secure environment that is supervised 24 hours a day, 7 days a week. CLIP program staff includes doctorate-level clinical staff, psychiatrics, nurses, social workers and direct care staff. Each CLIP program has a school on campus as well as recreational therapy, family therapy, skills groups, and individual therapy. The facility runs on a structured schedule. Treatment focuses on addressing the clinical needs you and your family and community team have identified prior to admission. Treatment is geared towards assisting you in becoming safe and to gain the skills necessary to transition back to your community. The average length of stay is from 6-12 months. A plan for your return to your community starts to be developed as soon as you begin treatment. It is called a discharge plan. Your discharge plan will be made with your input; as well as input from your treatment team and family. You can request discharge from the program at any time. Each program will explain the process for requesting discharge during your admission.

By agreeing to residential treatment you accept the need for inpatient treatment, have identified what you would like to work on while in treatment are willing to sign in to the program when an admission date is confirmed. Your family and community team will continue to be involved in your treatment through visitations, treatment planning meetings and ongoing contact and should be able to assist in answering any of the questions you may have about CLIP application and treatment process. Please feel free to look at our website which may provide you with more information about CLIP as well as pictures of the various CLIP programs, www.clipadministration.org

Please list or describe what you would like to achieve while in treatment:

Please sign below indicating you understand and are willing to accept treatment in a CLIP facility.

Signature of Youth requesting CLIP Treatment

Help Guide for CLIP Voluntary Application Form

The following suggestions are made as you go through the pages of the application:

Page Two:

1. **IEP or 504 Plan:** IEPs are plans required for special education students. 504 Plans are plans made by school districts to address special needs for some students, even if they are not qualified for special education.
2. **Medicaid/PIC#:** The number of the client is now known as the “Provider One” number or “Client Number” and is 8 digits followed by the letters WA.
3. **Private Insurance:** We are asking for other private health insurance that may be in effect for the child.
4. **Telephone:** Please also add an EMAIL address if you have one. CLIP office staff and other system staff are required to respect confidentiality if they send client information by email, and/or use an encrypted email system, but are able to discuss some arrangements by email. This speeds up communication.
5. Parents, please do not write in the shaded area.

Page Five:

1. Please include people currently (past 6 months) actively involved in helping the youth, If they will still be available to participate to help while the youth is in the CLIP program, please indicate with a check mark or *.
2. Please include family members, (even if reluctant or currently estranged), community members and community providers.
3. If some of these members have been meeting regularly as a team to address the youth’s needs, please indicate how often the team meets.

Page Six:

1. **What more intensive services have been tried....?** We are interested in which services listed on previous pages have been helpful, what was not helpful, and why (brief).
2. **Where will the child go after CLIP?** At completion of CLIP’s medical treatment period, the child will return home to their residence. If there is an alternative placement in mind, (DCYF placements or other family) please let us know here. For DCYF cases please list desired discharge placement.
3. **Youth’s Critical Issues and Needs:** Please use this section to be specific about the most important items to address in the child’s mental and behavioral functioning, and the most important family needs related to caring for the youth.

Page Seven:

Family's Critical Issues and Needs: Please use this section to be specific about the most important items to address in the child's mental and behavioral functioning, and the most important family needs related to caring for the youth.

Strengths: Listing these for the youth and family helps us use child and family strengths to more quickly help all make progress.

Barriers: Problems family may have working with CLIP program on visitation, therapy such as (schedule, geography. Child care, medical issues, transportation etc.) Knowing these early helps us plan for them.

Page Eleven: CLIP Application Materials Checklist/ Documents required:

Please provide relevant documents on this page for the last **Two Years of Services**. **Older documents are not required**, but you may submit them if you believe they are helpful to reviewers and do not repeat information reported elsewhere.

1. **Psychiatric Evaluation:** Must be done in the past 6 months, by a Psychiatrist (M.D), a; (medical doctor), or by a Psychiatric Advanced Registered Nurse Practitioner (ARNP). This is required to make sure the child needs this level of medical/psychiatric treatment.
2. **Inpatient Treatment:** Documents from last 2 years only needed; testing or evaluations done only when child was in this inpatient program.
3. **Outpatient Treatment:** Include Treatment or Discharge Summary, if available. Include Psychiatric Assessments if done. Include agency's mental health intake or admission assessment and any chemical dependency assessment. Include crisis service summary and crisis plan, if available. Do not include copies of daily chart or session notes.
4. **Department of Children, Youth and Families:** Provide only the most recent Court Report and Dependency Order. Provide group care summaries and/or CPS interventions for past two years.

Page Twelve:

1. **School:** Provide only the most current IEP and the last Evaluation Report/ Summary Evaluation (done every three years) for special education students.
2. **Other:** Parenting plan or visitation orders if currently applicable to parent visits/custody situation. Any legal contact or visitation restrictions.

CLIP Voluntary Application Help Guide is a product of:

CLIP IT

CLIP IMPROVEMENT TEAM