Dear Parent or System Partner;

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

The CLIP Application and all of the supporting documents need to be submitted to the CLIP Administration within 90 days from the Intensive Behavioral Health Staffing.

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 are only accepted via email in the form of a PDF. Clear scanned copies of each page are required.*
- *For most treatment and background information, the last Two Years of services and functioning is what we will be reviewing. Most children/youth 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.*
- *The Behavioral Health-Administrative Services Organization (private/uninsured/fee for service Medicaid) or your Managed Care Organization (Medicaid) will be able to assist you with the completion of this application.*

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DEMOGRAPHICS

Application Date: _____

Youth's Name:			*Date of Birth:*	
Medicaid Provider One Client ID#:			*Parent / Legal Guardian Name:*	

CURRENT PSYCHIATRIC EVALUATION

Current Psychiatric Evaluation dated within 6 months included?

☐ No
☐ Yes on date _____ with provider _____

A current psychiatric evaluation is required (please note the application will be considered incomplete if a current psychiatric evaluation is not included). 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-5 Diagnostic classification*
- *Includes at a minimum a Mental Status Exam, and Complete Assessment of Treatment needs of the applicant*

NARRATIVE SECTION

Has your child ever exhibited any inappropriate Sexualized Behaviors:

☐ *No*
☐ *Yes*

If yes, please describe:

Has your child ever had a Psychosexual Evaluation completed?

☐ *No*
☐ *Yes*

If yes, please include in application materials

*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.

Where will youth be going after treatment in CLIP?

Barriers family may have to participate in treatment?

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 **digital 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.*

1. Please attach completed Intensive Behavioral Health Screening Form
This form was used to determine this level of care was needed. Please attach the form along with the current Psychiatric evaluation completed and dated within 6 months.

***Please attach current Psychiatric evaluation completed within 6 months**.*
2. Current Psychiatric Evaluation
A current psychiatric evaluation is required. 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*

3. 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 (i.e FSIQ, ASD, FASD etc.)*

4. Outpatient Mental Health Treatment and Substance Use Disorder (SUD) Treatment
If youth has received outpatient mental health or substance use/alcohol use disorder 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*
- ☐ *Substance/Alcohol Use Disorder Assessment if applicable*
- ☐ *CANS Screen (not required for no insurance or private insurance)*
- ☐ *Outpatient Treatment Plan(s)*

5. 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*

6. Department of Children Youth and Families (DCYF)
If a youth has an open case with DCYF please provide:

- ☐ *Legal and Placement History*
- ☐ *Most recent Court Report*

- ☐ *Dependency Order*
- ☐ *Shelter Care Order*
- ☐ *CPS History for the past two years*

7. 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)*

8. 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 Administration 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*

9. Other

- *CLIP Application must be received within **90 days** from the Intensive Behavioral Health Screening*
- *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 5-12 years)*
- ☐ *Adoption decree if adopted*

If you have any questions regarding the application process, please call your local MCO, BH-ASO, or email the CLIP Administration at contactclip@clipadministration.org

Application Completed By:	
Name:	
Affiliation/Relationship to youth/adolescent:	
Phone number: *Email:*	

Please return and include all pages of this application by email.

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, psychiatrists, nurses, social workers and direct care staff. Each CLIP program provides educational services 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 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 are accepting the need for inpatient treatment. You have identified what you would like to work on while in treatment and 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 the 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 details of the various CLIP programs, www.clipadministration.org.

Please describe three goals you would like to achieve while in CLIP treatment:

1.

2.

3.

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

Signature of Youth requesting CLIP Treatment	
Date of agreement	

Please print, sign and return with application materials

HELP GUIDE

Narrative:

1. Youth's Critical Issues and Needs: *Please use this section to be specific about the most important items to address in the youth's mental and behavioral treatment. This could include medication management, diagnostic clarity, and specific treatment needs.*

2. Family's Critical Issues and Needs: *Please use this section to be specific about the most important family needs related to caring for, supporting and communicating with this youth.*

3. Where will the youth go after CLIP? *At completion of CLIP's medical treatment period, the youth 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.*

4. Barriers: *Problems family may have regarding visitation or family therapy such as (schedule, geography, child care, medical issues, transportation etc.) The CLIP programs benefit from knowing these early on.*

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. Intensive Behavioral Health Screening Form: *This form was reviewed by your local CLIP Team to determine if CLIP level of care was needed.*

2. 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 youth is in need of this level of medical/psychiatric treatment.*

3. Inpatient Treatment: *Documents from last 2 years only needed; testing or evaluations done only when youth was in this inpatient program.*

4. 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 substance use/alcohol use disorder assessment. Include crisis service summary and crisis plan, if available. Do not include copies of daily chart.*

5. Foster Care, In-home services, Residential care: *Include Treatment or Discharge Summary, if available.*

6. 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.*

7. School: *Provide only the most current IEP and the last Evaluation Report/ Summary Evaluation (done every three years) for special education students.*

8. Other: *Parenting plan or visitation orders if currently applicable to parent visits/custody situation. Any legal contact or visitation restrictions.*