CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR COMMUNITY BASED SERVICES
COA ACCREDITED AGENCY

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Contract Correspondence Transmittal (CCT)

CCT Number: 17-02	**Date of Issue:** June 8, 2017
Issuance: Division of Protection and Permanency, Director - Pam Cotton	
Key Words/Phrases: PCC/PCP Utilization Review, ALP, CANS	
Attachments/Forms: ALP (CRP-7) Form,	

Beginning July 1, 2017 (SFY 2018), the CBCL and the Reiss will no longer be accepted for a Utilization Review (UR). Instead, the most recent Child and Adolescent Needs and Strengths Assessment (CANS) completed during the Utilization Review (UR) reporting period is the expected tool to be submitted with each Application for Level of Care Placement (ALP) (CRP-7). When the CANS Report is not available, one or more of the following supplemental tools may be submitted. All supplemental tools must include child-related information from the current reporting period and provide information relevant to assigning a level of care. Refer to the level of care definitions identified in 922 KAR 1:360.

Supplemental Tools (When the CANS is not available)

- Assessment/Biopsychosocial
- Discharge information from previous placement (Must include information about child's progress and service needs.)
- DJJ/Court Information
- DPP-1294B
- IEP/Educational Information
- Medically complex information (including Individual Health Plan)
- Psychological Evaluation
- Psychiatric Hospital/PRTF information (e.g., discharge, treatment recommendations)
- Treatment Plan (Must include information about the child's progress on treatment goals.)

On-Line Training for Completing the Application for LOC Payment (ALP) (CRP-7)
A 1.25 credit hour on-line training for how to complete an Application for Level of Care Payment (ALP) (CRP-7) form is now available through Eastern Kentucky University's https://www.training.eku.edu/alpforpccpcpwbt

If you have any questions regarding this clarification, please contact Gayle Learned via email (gayle.learned@ky.gov) or by telephone at (502) 564-6852, ext. 3608.

CRP-7
11/14
922 KAR 1:360

CRP USE ONLY:	
CURRENT ALP DUE DATE	
CLINICAL REVIEWER:	

Children's Review Program (CRP)

Application for Level of Care Payment (ALP)

Directions: ***Complete each section in full and submit the completed form to the Children's Review Program and the child's DCBS Worker. Failure to complete this form in full may result in a delayed level of care.***

A. CHILD IDENTIFYING INFORMATION

Child's Name (Last, First)	Preferred Name	D.O.B.	Social Security #	Gender	Date of Admission

B. SERVICE PROVIDER INFORMATION

Agency		Program/Office Name		
Person Completing Form	**Date Completed**	**Telephone**	**Ext.**	**Fax Number**

Service Dates Covered by Report					
Reporting Period Beginning			Reporting Period Ending		
Month	Day	Year	Month	Day	Year

FOSTER CARE ONLY ☐ NA

Current Foster Family (Include First & Last Name)

If there have been any changes in foster home placement during this review period, excluding respite, specify below. ☐ NA

Reason for Move	From (Name of Foster Family)	To (Name of Foster Family)	Date of Move

C. CHILD'S SSW INFORMATION

State Worker's (First & Last Name)	County

D. CHILD STRENGTHS/PROGRESS

1	**Identify this child's strengths/interests.**
2	**Describe this child's progress on your phase/level system.** ☐ NA
3	**List child's current treatment goals and progress, including child's participation in and response to treatment OR attach a copy of the child's most recent treatment plan which provides information on progress toward goals.** ☐ Refer to attached Treatment Plan

REQUIREMENT: If this is the first ALP your program has completed for this child, attach the child's integrated assessment.

E. RISK BEHAVIORS ☐ NA

Identify any significant behavioral issues and complete the following information for each applicable behavior that has occurred during this reporting period. Note if legal charges were filed or medical attention was sought as a result of the incident. ***Do not report historical incidents (prior to this review period) or use terms such as "ongoing" as a means to communicate frequency.***

NA	Behaviors	Specific Dates of Occurrence	Details
☐	Animal Abuse		
☐	AWOL (e.g., off premises, whereabouts unknown)		
☐	Defiance/Authority Issues		
☐	Delinquent/Criminal Behavior		
☐	Destroys/Vandalizes Property		
☐	Fire Setting		
☐	Gang Affiliation/Interest		
☐	Homicidal Threats/Plans		
☐	Physical Harm to Others		
☐	Non-Compliant with Treatment Services		
☐	Self-Abusive/Self-Mutilating Behaviors		
☐	Sexual Behaviors		
☐	Substance Abuse (Exclude tobacco use; include positive drug screens.)		
☐	Suicidal Behaviors (e.g. attempts, ideation, threats)		
☐	Other:		

For any behaviors identified above that are not addressed in Section D-3 (current treatment goals and progress), describe how your program is addressing the issue.

F. METHODS OF INTERVENTION USED DURING THIS REPORTING PERIOD ☐ NA

Method		Number of Times Utilized	Has the frequency changed during this reporting period? If Yes (Y), explain.	
☐ NA	Use of Time-out (Do not include self-time-out)		☐Y ☐N	
☐ NA	Physical Management (Do not include escorts or assists)		☐Y ☐N	
☐ NA	Calling outside assistance (e.g. police, on-call agency staff)		☐Y ☐N	
☐ NA	Seclusion		☐Y ☐N	
☐ NA	Other (explain):		☐Y ☐N	

Does this child require any special supervision above normal programming or developmental norms? ☐Y ☐N If "Yes", describe below the type of supervision and how often it is required or attach the current supervision plan.

G. MEDICAL ISSUES ☐ NA

Describe any significant medical issues for which the child has received treatment during this reporting period and explain each condition and how caregiver time and resources were utilized. Provide the child's current height and weight.		
	Height	Weight

H. PREGNANT YOUTH ☐ NA

1	What is the anticipated due date (month/day/year)?	
2	Describe any current or potential pregnancy complications and the services being provided to address this youth's prenatal care.	

I. MEDICATIONS ☐ NA

List the child's current medications:

#	Medication	Purpose	#	Medication	Purpose
1			6		
2			7		
3			8		
4			9		
5			10		

J. MENTAL HEALTH ISSUES ☐ NA

1	List the child's current diagnoses based on the latest edition of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association.
2	If the child has had a psychological evaluation during this reporting period, please submit it with this ALP. If this is the first time your agency is including a diagnosis of an intellectual or developmental disability for this child, include documentation supporting this diagnosis (e.g. IQ testing, IEP),
3	Has there been a change in diagnosis during this reporting period? ☐ YES ☐ NO If Yes, explain the reason for the change in diagnosis.
4.	Has the youth disclosed, or been exposed to, any additional trauma during this reporting period? ☐ YES ☐ NO If yes, please describe

K. ADDITIONAL INTERVENTIONS ☐ NA

Complete the following for any services/interventions that occurred during the reporting period that required the child to stay in another location overnight (do not include home visits, etc.)

Service	Name of Service Provider	Reason	Dates
Psychiatric Hospitalization			
Crisis Stabilization			
Respite			
Other:			

L. SERVICES PROVIDED ☐ NA

Provide details of any mental health services this child has received during this reporting period.				
Service*	**# Sessions**	**Name of Agency/ Program Providing Service**	**Provider Name(s)**	**Identify Degree & License, if applicable**
Case Management				
Individual Counseling				
Family Counseling Identify participating members based on their relationship to the child (e.g., adoptive mother and stepfather, biological father, siblings, aunt, foster parents):				
Group Counseling				
Psychiatric (e.g., medication management)				
Substance Abuse				
Sexual Offender Treatment				
Sexually Reactive Treatment				
Independent Living (Ages 12+)				
Other (e.g. speech, physical therapy, occupational therapy, pregnant/parenting classes, IMPACT):				

If the child has not received the number or types of services as required by the PCC agreement or specified in the child's treatment plan, indicate the service and reason it was not provided. ☐ NA

*Note that each session should only be counted for one service. For example, the same session cannot be counted as both a case management and an individual therapy session.

M. EDUCATION

Current Grade	School Setting	Special Ed./Other Services Provided ☐ NA Identify primary disability & describe the services provided.
	☐ Pre-school/Head Start ☐ Public/Private School ☐ College ☐ Alternative School ☐ Day Treatment ☐ Homebound ☐ Partial Hospitalization ☐ Treatment Program (On-site School) ☐ G.E.D ☐ Vocational ☐ Other:	

If the school has completed an evaluation of this child or if a new IEP has been developed during this reporting period, plese include a copy of the report.

Describe current progress or lack of progress for each item.

Academic Functioning/Grades	
Behavior Problems (e.g. truancy, defiance)	
Other (explain):	

N. DAILY LIVING/SOCIAL SKILLS

Describe the child's interactions/relationships with others as they relate to healthy boundaries and ability to develop bonds..
Provide a summary of the child's ability to maintain his/her personal hygiene/appearance and complete chores/tasks independently, as appropriate to age and developmental level.

O. DEVELOPMENTAL CONCERNS ☐ NA

Describe any developmental concerns, including issues with communication, mobility, feeding, drinking, and toileting issues. The reporter should take into account developmentally appropriate skills for child's chronological age and developmental level.
Based on the developmental concerns identified above, describe the child's capacity to participate in his/her treatment.

P. PARENTING YOUTH ☐ NA

Identify youth's children.

Child's Name	Age	Does the youth currently live with this child?	If the youth is not living with this child, what is the current contact or visitation plan?
		☐Yes ☐No	
		☐Yes ☐No	

Describe this youth's current parenting responsibilities and skills, including strengths and potential risk factors.

Q. LEGAL CONSIDERATIONS ☐ NA

Describe any ongoing unresolved legal issues for this child.

R. DCBS PERMANENCY GOAL & CURRENT DISCHARGE PLAN

1	Select the child's current DCBS permanency goal. ☐ Return To Parent ☐ Adoption ☐ Legal Guardianship ☐ Emancipation ☐ Permanent Relative Placement ☐ Planned Permanent Living Arrangement
2	If parental rights have been terminated during this reporting period, provide the date of termination. ☐ NA
3	Describe the services and treatment interventions that your agency is providing to support and promote this child's family connections and permanency. If no services are being provided, explain.
4	Describe the current discharge plan and indicate the reason for any change during this reporting period.
5	What is the child's projected discharge date?

S. VISITATION/CONTACT INFORMATION ☐ NA

Report any visitation by persons outside the current placement agency (e.g., DCBS worker, relatives, etc.) including the dates and results of the visits.				
Date/Length of Visit	**Name of Person Visiting with Child**	**Relation to Child**	**Location of Visit**	**Result of Visit (Give a brief description)**

T. INDEPENDENT LIVING ☐ NA

1	**Identify youth's current employment and any employment the youth may have had during this reporting period. Include dates of hire and employment, position/duties, and performance level.** ☐ **NA**
2	**For youth in independent living programs, describe this youth's current living arrangement and identify any issues or concerns.** ☐ **NA**

U. ADDITIONAL CONSIDERATIONS ☐ NA

Provide any additional information and recommendations for services.

Signature of Agency Representative _____ Date _____