**Therapy Exception Form**

Please complete the form by responding to the items below to explain the need for the therapy exception. The completed form may be emailed to Holly Davis at [hollyc.davis@ky.gov](mailto:hollyc.davis@ky.gov), PCC Liaison in DCBS Central Office.

|  |  |  |  |
| --- | --- | --- | --- |
| **Agency:** |  | **Staff:** |  |
| **Child’s Name:** |  | **DOB:** |  |

**Please select one of the allowable exceptions listed below**:

|  |  |
| --- | --- |
|  | An effort to maintain a prior therapeutic relationship, when the assessment and treatment plan indicate that this previously existing relationship is in the best interest of the child.  As a general rule, a child should have been in therapy with this specific Provider for six (6) months or more prior to requesting this exception; |
|  | An effort to link the child to the community so that they have access to services after discharge; or |
|  | Accessing specialty services deemed necessary through the assessment, but that the Provider is not equipped to provide, such as autism spectrum disorders, fetal alcohol syndrome, other genetic disabilities, intensive substance abuse treatment, and intensive treatment for sexually offending youth. |

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| **Please provide a brief description of the reason for the exception request.** |
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Please note that as of April 3, 2019 there has been clarification in relation to the services that are to be covered by the bundled rate payment (Title V Agreement). The following services are intended to be within the bundled rate provided to Private Child Placing and Private Child Caring Providers:

* Individual Therapy, Group Therapy, Family Therapy and Collateral Therapy
* All Screenings and Assessments
* Service/Treatment Planning
* Case Management

|  |  |  |  |  |  |  |  |  |  |  |  |
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| Signature |  | Date | | | | |  |  |  |  | Credential |
|  |  | |  |  |  |  | | | | | |
| Phone Number |  | |  |  |  | Email Address | | | | | |

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PCC/PCP Liaison Date

Approved

Not Approved