4/30/2012

FAIRFAX-FALLS CHURCH CSA Print Date:

Residential – Group Home UR Report

Review Date: 08/31/2011

Name: Test Test UR Analyst:

Service Type: ❑ RTC ❑ Group Home **Type of UR:** ❑ Initial ❑ Request for Extension

1. **The youth meets the criteria for an RTC/ GH level of care based on identified needs, risk behaviors, and current functioning.** ❑ Yes ❑ No ❑ Cannot assess ❑ Not applicable

2. **Youth and caregiver strengths, available community resources, and prior/current lesser restrictive interventions have been considered before determining the need for an RTC/GH level of care.** ❑ Yes ❑ No ❑ Cannot assess ❑ Not applicable

3. **The treatment plan developed in collaboration with the youth/family, case manager, CST members, and private provider is comprehensive and adequately addresses the identified needs, risk behaviors, and functioning of the youth and his/her family.**
   ❑ Yes ❑ No ❑ Cannot assess ❑ Not applicable

4. **The IFSP and/or agency service plan includes services that are necessary for the youth to successfully step-down to the community to return to a family setting in a timely manner.**
   ❑ Yes ❑ No ❑ Cannot assess ❑ Not applicable

5. **The treatment plan provides clear discharge criteria and a realistic discharge date.**
   ❑ Yes ❑ No ❑ Cannot assess ❑ Not applicable

Other UR recommendations or comments for the FAPT:

Sources of Information: _____
UR Specialist Signature: _____