



QUALIFIED RESIDENTIAL TREATMENT PROGRAM (QRTP) CONTINUED STAY REVIEW (CSR)

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
CHILDREN AND FAMILY SERVICES
SFN 826 (7-2021)

Directions: This form is completed by the custodian for all children placed in a QRTP for treatment. The continued stay review form must be completed no greater than 30 days prior to placement expiration and no less than 20 days before the placement approval expires. The Qualified Individual will have 10 days to review the request for the child to continue in a QRTP. The custodian is responsible to track the placement length of stay and work with the QRTP to ensure treatment progress is being made.

CHILD INFORMATION		
Last Name	Name (First, Middle Initial)	Age Today
FC Case Number (FRAME)	Court Case File Number	

QRTP INFORMATION	
Name of QRTP Facility	
Contact Name	Telephone Number
QRTP Continued Stay Review Type <input type="checkbox"/> 3 Month <input type="checkbox"/> 6 Month <input type="checkbox"/> 9 Month <input type="checkbox"/> 12 Month	Total Number of Days in a QRTP (during child's foster care episode)
Admit Date to Current QRTP	

INFORMATION SOURCES	
<input type="checkbox"/> No information source changes since last review <input type="checkbox"/> Changes have occurred and are listed below (only list changes)	
Case Manager (CM) Name	CM Telephone Number
CM Email Address	CM Fax Number
Legal Custody Type <input type="checkbox"/> County <input type="checkbox"/> DJS <input type="checkbox"/> Tribe <input type="checkbox"/> Parent	Legal Custodian Name
Parent's Name	Parent's Telephone Number
Parent's Name	Parent's Telephone Number

Include on this chart primary supports or Child and Family Team (CFT) members who are involved in the child's case plan.

Name of Primary Support or Child & Family Team Member	Relationship to Child (mother, father, sibling, grandparent, guardian ad litem, foster parent, teacher, etc.)	Telephone Number	Involvement 1 = Minimal 2 = Inconsistent 3 = Involvement Pending 4 = Consistent with Limited Engagement 5 = Consistent and Engaged	Types of Supports C = Calls L = Letters V = Visits O = Other (describe)

Involvement - If rated 1,2,3, or 4 above, describe each primary support's involvement in further detail, giving specific examples.

CHILD'S CURRENT AND CONSISTENT BEHAVIOR/SYMPTOMS This is specific to the past 30 days only. Provide only the recent progress notes and incident reports.
List mental health, intellectual, developmental and substance related diagnosis. D=Daily; W=Weekly; M=Monthly

	D	W	M		D	W	M		D	W	M
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Property destruction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual aggression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Danger/violence to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fighting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sexual exploitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Threatening behaviors or actions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fire Setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Substance use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School Refusal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Harm to animals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other: _____			
School Misbehavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Harm to self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other: _____			
Intentional Misbehavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal threats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other: _____			
Impulsivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal attempts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diagnosis: _____			
Self care/Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Delinquent behavior	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diagnosis: _____			
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Peer relationship issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Diagnosis: _____			

REASON FOR CONTINUED STAY

What current (within the last 90 days) /consistent behaviors and symptoms require continued treatment in a QRTP?

What are the least restrictive options being ruled out or determined insufficient (such as a family setting) ?

What service and supports would be necessary for the child to return to a family setting? (**Note:** Completion of QRTP treatment is not an acceptable response without specific goals identified)

What is the anticipated discharge date and detailed discharge plan? If the discharge date has changed since admissions, explain why:

Describe all discharge planning action steps that have occurred since QRTP admission.

Requesting approval for stay beyond the placement maximum:
 Yes - see 624-05-20-17 and answer the next question No

Answer if only requesting continued stay beyond the placement maximum. If yes, provide the narrative below following policy 624-05-20-17:

In order to accept the application, the referral must attach details from the **past 90 days** specific to:

- QRTP treatment plan, progress notes, therapy notes, incident reports and psychiatric notes;
- Child and Family Team meeting notes or most recent permanency plan (if in public custody); and
- Any assessments, testing, IEP, medication, diagnosis, or specialist evaluations not previously submitted to Ascend.

REFERRAL INFORMATION		
Who completed the form? <input type="checkbox"/> Case Manager <input type="checkbox"/> Parent <input type="checkbox"/> Other: _____		
Name of Referrer		Referral Date
Email Address	Telephone Number	Fax Number