

Psychiatric Residential Intensity of Service Questions

Facility Name: _____

Name of Person Completing the Form: _____

Title: _____

Date Completed: _____

Ages treated: _____

Is your facility accredited? YES NO

If yes, by which organization: _____

Is the facility licensed by the appropriate state agency?

YES NO

If Yes, please provide state agency: _____

Please provide copy of licensure

If the answer is no, please explain with further detail:

Please review the Level of Care Utilization System (LOCUS) and Child and Adolescent Level of Care Utilization System (CALOCUS) documentation at the link below and attest that you meet the criteria as defined here.

[LOCUS & CALOCUS Criteria](#)

I attest that I've reviewed the LOCUS & CALOCUS Criteria for this level of service and meet the requirements as defined.

YES NO

If the answer is no, please explain with further detail:

Please provide copy of program description and relevant policies supporting the LOCUS & CALOCUS criteria and below requirements for this level of care.

1. The member's history and physical examination with medical clearance is completed and documented within 48 hours of admission, unless completed within 72 hours prior to admission or if transferred from an acute inpatient level of care.

YES NO

If the answer is no, please explain with further detail:

2. Drug screens and relevant lab tests are completed and documented upon admission, as clinically indicated.

YES NO

If the answer is no, please explain with further detail:

3. Attending physicians are psychiatrists and are responsible for completing diagnostic evaluation within 48 hours of admission.

YES NO

If the answer is no, please explain with further detail:

4. The physician or physician extender provides medical monitoring and evaluations a minimum of weekly and the physician is available 24 hours per day seven days per week.

YES NO

If the answer is no, please explain with further detail:

5. After a multidisciplinary assessment, and within 72 hours of admission, an individualized treatment plan using evidence-based concepts, where applicable, is developed and amended as needed for changes in the individual's clinical condition.

YES NO

**Please note: This plan should reference the following to develop treatment and discharge plans focused on the member:*

- | | | |
|---|-----|----|
| a. Precipitants to admission, including social determinants of health | YES | NO |
| b. Family/other support systems available after discharge | YES | NO |
| c. Community resources | YES | NO |
| d. Need for supportive living placement to continue recovery | YES | NO |
| e. Need for services for comorbid medical or psychiatric conditions | YES | NO |

If the answer is no, please explain with further detail:

6. Intensive treatment is provided at least five days per week and includes individual, group, and family therapy depending on client needs.

YES NO

If the answer is no, please explain with further detail:

7. The members are evaluated daily by a licensed behavioral health practitioner.

YES NO

If the answer is no, please explain with further detail:

8. Mental Health and Medical services are available 24 hours per day, seven days per week, either onsite, via telehealth, or offsite by arrangement in close enough proximity to always provide a rapid response.

YES NO

If the answer is no, please explain with further detail:

9. Onsite nursing (e.g., LPNs) is available at least 8 hours a day, five days a week and RNs are available 24 hours a day and respond to significant clinical events with a rapid response.

YES NO

If the answer is no, please explain with further detail:

10. Onsite licensed clinical staff is available 24 hours a day, seven days a week adequate to supervise the member's medical and psychological needs.

YES NO

If the answer is no, please explain with further detail:

11. A multidisciplinary treatment program provides daily clinical services to comprehensively address the needs identified in the member's treatment plan.

YES NO

If the answer is no, please explain with further detail:

12. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan within 72 hours of admission.

YES NO

If the answer is no, please explain with further detail:

13. Family participation:

- a. Family treatment is provided at an appropriate frequency. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy.

YES NO N/A

If the answer is no, please explain with further detail:

- b. For children/adolescents: The family/support system assessment is completed with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur as clinically indicated.

YES NO N/A

If the answer is no, please explain with further detail:

- c. For children/adolescents: The family/support system assessment is completed within 5 days of admission with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur at least weekly or more often if clinically indicated.

YES NO N/A

If the answer is no, please explain with further detail:

- d. Family participation is conducted via telephonic sessions when there is a significant geographic or other limitation.

YES NO

If the answer is no, please explain with further detail:
