DAUPHIN COUNTY RFTA INSTRUCTIONS (FY 2019-2020)

Please complete the RFTA Form (Request for Treatment Authorization) completely. RFTAs that are not completed correctly or in full will not be accepted by the Assigned Case Manager.

Individual and Birth Name: Please be sure to verify the legal and birth name of the individual.

Date of Initial Contact: This is the date the client first contacted your facility. This is usually the same as the "Date of Screening."

Individual's Employer: Name of the individual's employer. If unemployed, write N/A.

Insurance Info: This is the type of insurance they carry. If they have none, write N/A.

MA Status: Circle one of the choices provided. The individual should have applied for or be instructed to apply for Medical Assistance. The SCA should **not** be funding individuals who are eligible for Perform Care.

Reason for Funding Request: If the individual has another funding source, list the reason for the funding request. If the person has insurance and is being denied, please attached the denial letter from the insurance company. If the individual is unable to afford their co-pay/deductible, please attach documentation of his/her of out of pocket expenses and a grievance letter from the individual.

Referring Agency: The agency who referred the individual to your facility. For example, if the individual is involved with the criminal justice system it may be "Adult Probation."

Name of the Person Referring: This will be the individual's name if it is a self-referral. If someone else referred them, please put their name in the space provided.

Probation Officer Name: Put the individual's PO's name in the space provided. If the individual does not have a PO, write N/A.

Date of Screening: Put the original date that the individual was screened for appropriateness for treatment. This may be the same date as the initial contact date.

Date of Assessment: Put the date of the individual's completed drug and alcohol assessment.

If Applicable, Reason for Delay: After the individual is screened, their intake appointment is expected to occur within seven (7) calendar days. If the screening and assessment are completed within the seven (7) day timeframe, write N/A in the space provided. If the individual cannot be seen within seven (7) days of the assessment because the provider is unable to accommodate the timeframe, the individual must be referred to another treatment provider. If the individual chooses to wait for an appointment rather than go through another provider, this must be documented in the space provided. Also, if the

individual is offered an appointment within seven (7) days, but chooses to wait, the specific reason must be documented in the space provided.

Is the Individual pregnant? / Any minors in her custody?: This applies only to the children the individual has under their care, not to children that do not live with the person. Answer this question only for female individuals. If the individual does not have children or is male, write N/A.

Co-Occurring Individual?: If the individual has a mental health diagnoses in addition to their drug and alcohol diagnoses, circle yes.

Has the Individual ever been an Injection Drug User?: Circle the appropriate response. The individual must be admitted within fourteen (14) days. Those in need of withdrawal management must be admitted within twenty-four (24) hours.

Were interim services offered?: Circle the appropriate response. Individuals in need of emergent care must have those needs addressed at the time of identification.

Is the Individual an Overdose Survivor?: Circle the appropriate response.

Level of Care Recommendation: Circle the appropriate level of care recommendation. This will be the same level of care that is indicated on the individual's completed ASAM.

Level of Care Received: Circle the level of care that the individual actually received. If the level of care recommended and if the level of care received are different, state the reason why.

Scheduled Start Date: The date that the individual was scheduled to begin the actual treatment.

Primary Drug Of Choice: List the individuals current drug of choice.

Requests for approvals need to be submitted within three (3) business days from the funding start date.

Please leave the portion marked *"SCA Use Only"* **blank.** The assigned Case Manager will complete the form accordingly and send it back to confirm approval for funding.

PROVIDER CHECKLIST

Where appropriate, the following forms **MUST** be signed by both the individual and counselor. All these are to be faxed with the RFTA Form. (Liability Forms are not required for adolescents.)

All forms must be received in order for the Assigned Case Manager to approve treatment.

- ☐ **Treatment Approval Form** *(front 2 pages)*
- ☐ **Grievance and Appeal Form**
- ☐ **Treatment Limitations**
- ☐ **Consent** *(SCA's consent to the Provider)*
- ☐ **Liability Form**
- ☐ **Proof of Residency** *(Individual must provide proof of a minimum of three (3) months of Dauphin County residency by identification, current service bill, or other documentation. If this is unable to be obtained, please document the reason why - such as homelessness.)*
- ☐ **Proof of Income** *(Individual must provide documentation showing their current income, such as a paycheck statement. If there is no income, be sure to indicate that on the liability form.)*

PA WITS Entries

- ☐ **Client Information (Profile)**
- ☐ **Client Intake**
- ☐ **Screening Tool**
- ☐ **TAP**
- ☐ **Admission/Referral**
- ☐ **ASAM**
- ☐ **Consent to T-Dauphin SCA:** Client Profile, Intake, Screening, TAP, Admission/Referral, ASAM, Discharge, Recovery Plan
- ☐ **Recovery Plan**

DAUPHIN COUNTY DEPARTMENT OF DRUG AND ALCOHOL SERVICES
1100 South Cameron St. – 1st Floor Right, Harrisburg, PA 17104
Phone: (717) 635-2254 – Confidential Fax: (717) 635-2267

REQUEST FOR TREATMENT APPROVAL – FY19-20

NAME: _____ DATE OF INITIAL CONTACT: _____

SSN: _____ BIRTH NAME: _____

CURRENT ADDRESS: _____ DOB: _____

_____ RACE: _____

_____ MARITAL STATUS: _____

SEX: _____ PHONE # : _____

HOME ADDRESS OF RESIDENCE *(IF DIFFERENT FROM ABOVE)*: _____

_____

INDIVIDUAL'S EMPLOYER: _____

INSURANCE INFO: _____

MA STATUS *(CIRCLE ONE)*: ACTIVE DENIED PENDING

IF MA OR PRIVATE INSURANCE IS ACTIVE, WHAT IS THE REASON FOR THE FUNDING REQUEST?

_____

REFERRING AGENCY: _____ PHONE#: _____

NAME OF PERSON REFERRING: _____

PROBATION OFFICER NAME: _____

DATE OF SCREENING: _____ DATE OF ASSESSMENT: _____

IF APPLICABLE, REASON FOR DELAY (7 DAY REQUIREMENT)_____

_____

IS INDIVIDUAL PREGNANT? YES NO ANY MINOR CHILDREN IN THEIR CUSTODY? YES NO

CO-OCCURRING INDIVIDUAL? YES NO IS INDIVIDUAL A VETERAN? YES NO

EVER BEEN AN INJECTION DRUG USER? YES NO INTERIM SERVICES OFFERED? YES NO

OVERDOSE SURVIVOR? YES NO

LEVEL OF CARE RECOMMENDATION: *(circle one)*

0.5 1 2.1 2.5 3.1 3.5 ST 3.5 LT 3.7 3.7 WM 4 4WM OTS

LEVEL OF CARE RECEIVED: *(circle one)*

0.5 1 2.1 2.5 3.1 3.5 ST 3.5 LT 3.7 3.7 WM 4 4WM OTS

IF THE LEVEL OF CARE RECEIVED IS DIFFERENT FROM THE RECOMMENDATION EXPLAIN WHY:

_____

SCHEDULED START DATE: _____

CURRENT DRUG OF CHOICE: _____

ASSIGNED COUNSELOR: _____

DATE RFTA PACKET FAXED OR EMAILED TO SCA: _____

PROVIDER'S FAX # FOR SCA TO SEND APPROVAL: _____

SCA USE ONLY

DAUPHIN COUNTY DEPARTMENT OF DRUG & ALCOHOL SERVICES
APPROVAL FORM

TO: _____ FROM: _____

_____ _____

PROVIDER: _____ DATE SENT: _____

FAX NUMBER: _____

INDIVIDUAL FOR REVIEW: _____

DATE OF REVIEW: _____

APPROVAL STATUS: Approved Denied Pending

REASON FOR DENIAL: _____

CASE MANAGER ASSIGNED: _____

APPROVAL START/ END DATE:_____**For LOC:**_____

Comments:

_____

_____

_____

_____

***All approvals are contingent on available funding.**

CONFIDENTIAL

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulations (42 CFR Part 2 and HIPAA Law of 1996) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. If you have received this information in error, please destroy it immediately and then notify this agency.

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GRIEVANCE AND APPEAL POLICY

If the client has concerns, complaints, or problems with a decision made by the Dauphin County Department of Drug and Alcohol Services the client may contact the department regarding resolution of the identified issues.

- **Clients may grieve the following 4 (four) issues.**

  A. Denial or termination of services
  B. Level of care determination
  C. Length of stay in treatment
  D. Violation of human or civil rights

- **The grievance and appeal procedure once initiated is as follows:**

  (1) Client may appeal in writing to the Grievance Review Board which is made up of agency staff including case management, prevention and administrative personnel. The Grievance Review Board will make a decision about your grievance within seven (7) days and will notify you and The Department of Drug and Alcohol Programs in writing using the DDAP Grievance and Appeal Reporting Form. No client identifying information will be included or attached to the grievance and appeal form.

  (2) If the client is not satisfied with the resolution by the Grievance Review Board the client can appeal to the SCA Administrator. The SCA Administrator will make a decision about your grievance within seven (7) days and will notify you and The Department of Drug and Alcohol Programs in writing of the outcome using the DDAP Grievance and Appeals Reporting Form. No client identifying information will be included or attached to the grievance and appeal form.

  (3) FINAL APPEAL is made to an independent panel consisting of three people and may include Dauphin County Drug and Alcohol Advisory Board members, a drug and alcohol case manager from another SCA and a person in recovery. No one on this panel may have financial or contract ties to the Dauphin County Department of Drug and Alcohol Services. You will be asked to sign appropriate consent forms to permit release of information related to your case for the purpose of review as it pertains to your appeal. The panel will make a decision about your appeal within seven (7) days and both you and The Department of Drug and Alcohol Programs will be advised of the outcome using the DDAP Grievance and Appeals Reporting Form.

- The client has the right to have access to all documentation pertaining to the resolution of the grievance within the confines of state and federal confidentiality regulations;
- The client has the right to be involved in the process and have representation by means of a client advocate, case manager or any other individual chosen by the client at each level of appeal.

_____ _____
STAFF SIGNATURE **Date**

_____ _____
CLIENT SIGNATURE **Date**

I have been offered a copy. (Client initials): _____

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TREATMENT LIMITATIONS FORM

This agreement is between the funding agency, Dauphin County Department of Drug and Alcohol Services and _____ .
(Individual)

All individuals must sign this form regardless of Level of Care or a no treatment determination.

The following is a list of terms for this agreement:

1. Individuals who fail to follow treatment recommendations or follow facility rules, when applicable, will not be eligible for SCA funding for three (3) months.
2. Individuals are eligible for one (1) Level of Care Assessment per six (6) months. This includes Level of Care assessments completed by the Dauphin County Department of Drug and Alcohol Services' staff or its contracted treatment providers.
3. The individual agrees that if housing services are requested, the individual must participate in services recommended based on the licensed drug and alcohol assessment. If the individual fails to participate in recommended services for any reason, the Dauphin County Department of Drug and Alcohol Services will not fund for housing services. Emergency housing funding may be eligible for up to thirty (30) days.
4. The individual is eligible for one (1) non-hospital residential rehabilitation stay per fiscal year. Individuals must meet with SCA staff when requesting additional treatment stays.
5. Detox admission is permitted once per six (6) months not to exceed two admissions per year; however, the Dauphin County Department of Drug and Alcohol Services can approve admission upon emergent care determination.
6. The individual is eligible to receive a lifetime maximum of one (1) year of funding for Medication Assisted Therapies.
7. The individual understands that signing this Treatment Agreement indicates that the individual has read or has had it read to him/her.

* Treatment limitation restrictions do not apply to priority populations except in the instance of residency outside of Dauphin County.

_____ _____
Signature of Individual Date

_____ _____
Signature of Witness Date

Copy Received: Accepted ( ) Declined ( )

Rev 6/2019

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RELEASE OF INFORMATION FORM

CLIENT NAME: _____ **SS#:** _____ **DOB:** _____

I voluntarily give my consent to the Dauphin County Department of Drug and Alcohol Services to *release* information to the following individual or agency:

_____

(Name of individual/Agency)

Information released will be limited to the following:

_____ Whether the client has relapsed into abuse and Frequency of such relapse
_____ Whether the client is or is not in treatment
_____ The nature of the project
_____ Prognosis/Diagnosis of the Client
_____ Description of the client's progress
_____ Other (Specify): _____

For the purpose(s) of:

_____ Referral for Treatment Services
_____ To monitor the provision of ongoing treatment
_____ To enable judges, attorneys, probation/parole officers to support treatment goals and/or make legal decisions on the client's behalf
_____ To obtain insurance, employment or government benefits
_____ Referral to intensive case management or other support services
_____ Other (Specify): _____

I have read this form or had it explained to me and I understand its contents.

_____ _____
Signature of Client **Date** **Signature of Witness** **Date**

_____**(Specify date, event, or conditions pertinent to the situation)**
Expiration Date

I have been offered a copy of this document. Accepted ( ) Declined ( )

I understand that the above information has been disclosed for records whose confidentiality is protected by Federal and State Regulations. (Federal Law 42 CFR Part 2, HIPAA Law of 1996, PA Code 255, PA Code 257, & Act 63). Federal Regulations (42 CFR Part 2 and HIPAA Law of 1996) prohibit any further disclosure, unless disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization of the release of medical or other information is not sufficient.

I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance of my consent. Also, I understand that in order to revoke my consent a request may be made verbally and/ or in writing to any Dauphin County Department of Drug and Alcohol Services staff member.

The agency or individual to whom information is sent is prohibited from re-disclosing this information to another party without my consent.

Rev. December 2012

CLIENT LIABILITY DETERMINATION FORM

(Please refer to Section 7.08 of the DDAP Fiscal Manual for completion of the form.)

☐ Initial
☐ Re-determination

Date: _____

Client Name	County of Residence	Client ID #

PART I: INSURANCE

Does the client have insurance (private and/or public) coverage? Yes ☐ No ☐

If insurance has been denied, indicate the reason for denial.

Denied:

Insurance Company	Name of Insured	Group #	ID #

If the SCA is not reimbursing for the cost of service or the service is exempt, DDAP does not require completion of the form.

PART II: FAMILY (As determined by Federal Law/Federal Tax Return)

Name of Dependents	Relationship
	Self

Total # of Dependents (including Self): ☐

PART III: MONTHLY GROSS INCOME

List all income from full- and part-time employment as well as other types of income, as applicable, including that of Self, Spouse and Parents (see Section 7.03 of the DDAP Fiscal Manual for income to be included). See description of types of income below.

Family Member	Employers
Self	
Spouse	
Parent I (if applicable)	
Parent II (if applicable)	

Types of Income	Self	Spouse	Parent I	Parent II	Totals
Earned Income (i.e., wages, salaries, tips, bonuses, etc.)					$0
Interest Income					$0
Dividends					$0
Benefits (i.e., unemployment, social security, public assistance, pensions, etc.)					$0
Alimony					$0
Other Taxable Income					$0
Totals	$0	$0	$0	$0	$0

Total Monthly Gross Income $0

DESCRIPTION OF TYPES OF INCOME

Earned Income:	Wages, salaries, fees, commissions, tips, bonuses, net business income and other earned income subject to Federal income taxation.
Interest Income:	Interest income including, but not limited to, interest received from accounts with banks, savings and loan associations, money market funds, credit unions or bonds.
Dividends:	Dividends received from corporate stock holdings or cash dividends from life insurance policies.
Benefits:	Taxable benefits, including but not limited to unemployment compensation, Social Security payments and pensions. Benefits are counted as income only if the benefit is paid on behalf of the client. Food stamps are not counted as income.
Alimony:	Includes alimony received or spousal support received prior to divorce. Does not include child support.
Other taxable income:	Includes all other income subject to Federal income taxation, e.g., rental income, lottery winnings, net capital gains, etc.

PART IV: CLIENT LIABILITY

Total # of dependents (listed in Part II): 0

Total Monthly Gross Income (listed in Part III): $0

		CLIENT LIABILITY DUE							
Service	Applicable Liability Percentage*	Individual Hour	Group Hour	Group Session	Day	Week	Urinalysis	Dosing	Other (Specify)
Outpatient					xxxxxxxx	xxxxxxxx		xxxxxxxx	
IOP						xxxxxxxx		xxxxxxxx	
Partial						xxxxxxxx		xxxxxxxx	
Halfway House	xxxxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx		xxxxxxxx	xxxxxxxx	xxxxxxxx	
Residential	xxxxxxxxxx	xxxxxxxx	xxxxxxxx	xxxxxxxx		xxxxxxxx	xxxxxxxx	xxxxxxxx	
Methadone									
Other (specify)									

*Minimum co-pays may apply

AGREEMENT AND UNDERSTANDING:

I certify that the information concerning my dependents, insurance and income is true and complete to the best of my knowledge. I understand that I am responsible for paying the above fees on the same day of service. I understand that I am to notify this agency if there are any significant changes in my monthly income or family size within 30 days of such change. I understand that if these fees represent a financial burden, a staff person and I may fill out a REQUEST FOR LIABILITY REDUCTION OR ELIMINATION form.

A copy of this form has been offered to me and I have _____ accepted _____rejected it.

_____ _____
Client Signature Date

_____ _____
Staff Signature/Witness Date

_____ _____
SCA Signature (as applicable) Date

Note: Client Liability determined on this day shall be valid for a period of no more than 12 months, with a re-determination to occur at the end of the 12-month period.