Reset Form

Psychiatric Residential Treatment Facilities (PRTF)

FYI ***Incomplete, illegible or inaccurate forms will be returned to sender.*** Please complete the entire form and allow 14 calendar days for decision.

For questions, call Mental Health and Substance Use Disorder Services at: **612-676-6533** or **1-833-276-1185**

To **fax** form and any relevant documentation: **612-884-2033** or **1-855-260-9710**

Submit Request: UCare's Secure Email Site
Intake: MHSUDservices@ucare.org

MEMBER INFORMATION

UCare ID _____ PMI _____

Member Name _____ DOB _____

Address _____

City, State, Zip _____ Phone _____

Current out of home placement? ☐ No ☐ Yes, _____ *(Placing Agency)*

Describe Living Arrangement:

SERVICING CLINIC INFORMATION

IMD NPI or UMPI ID _____
(Add only the facility identification number designated as IMD by DHS)

Servicing Clinic _____

Location Address _____

City, State, Zip _____

Contact Phone _____ Fax _____

REQUESTER INFORMATION

Request Sent By _____ Email _____

Phone _____ Total Pages Faxed _____

UCare Case Managers may assist in the coordination of services to provide the quality care that is customized accordingly to aid members to their recovery.

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ELIGIBILITY FOR ADMISSION TO PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

Admission Date to PRTF	Date of most recent DA	ICD-10

Any behavioral or psychiatric symptoms requiring treatment (describe below)

Any severe, chronic and frequent aggression or danger to self or others (describe below)

Any functional impairment (unable to maintain behavioral control, frequent interpersonal conflict, unable to appropriately engage in activities of daily living, describe below)

Describe exacerbating symptoms, including history of onset of all symptoms (including the above)

Current medications (list names, dosage and condition treated)

HISTORY OF HOSPITAL OR RESIDENTIAL TX

Name of facility _____

Dates of admission & discharge _____

Reason for admission _____

Name of facility _____

Dates of admission & discharge _____

Reason for admission _____

OTHER COMMENTS