STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

CLINICAL SUMMARY FORM

for QRTP (Qualified Residential Treatment Program) ADMISSION ASSESSMENT

INSTRUCTIONS

The **QRTP Clinical Summary Form** (this form) provides a SUMMARY of the QRTP Clinical Admission Assessment and justification or not for QRTP placement.

The QRTP Clinical Admission Assessment determines if the identified youth needs a QRTP setting to provide the most effective and appropriate level of care in the least restrictive environment consistent with the youth's short- and long-term goals.

THE QRTP ADMISSION ASSESSMENT INCLUDES

1. **A Clinical Assessment:** A comprehensive, face-to-face clinical/behavioral health assessment provided by a qualified clinician who also completes this summary form. This might be done in person or through appropriate and secure virtual technology (telehealth).
   - **a.** The QRTP Admission Assessment must be completed by a qualified clinician (licensed clinician).
   - **b.** There is not a standard, required, or recommended clinical assessment tool – this is determined by the qualified clinician's professional choice.
   - **c.** The clinical assessment is due within 30 days of the admission date.
   - **d.** The preference is to have this completed PRIOR to admission to the QRTP.

2. **The TOP (Treatment Outcome Package) Tool:** TOP assesses a youth's treatment needs and is completed by the clinician, the youth, AND all other appropriate collaborating individuals. **The assessing clinician (LPHA) must complete the TOP as part of the full QRTP Admission Assessment.** Service providers have access to complete TOP or an online link to the tool may be sent by the HHS/JCS Referring Worker.

3. **QRTP Placement Determination:** Justification for QRTP placement and the youth's qualification for QRTP placement is identified by the clinician on this Clinical Summary Form.

(Continued)

CLINICAL SUMMARY FORM for QRTP ADMISSION ASSESSMENT

YOUTH NAME _____ **CLINICAL ASSESSMENT DATE** _____

DOB _____ **ASSESSING CLINICIAN** _____

CURRENT PLACEMENT

- ☐ Family home Foster
- ☐ family home
- ☐ Detention Shelter
- ☐ Hospital
- ☐ QRTP
- ☐ Other:
- ☐ _____

REFERRAL SOURCE

- ☐ HHS
- ☐ JCS

COLLABORATING INDIVIDUALS

- ☐ Parents
- ☐ Relatives
- ☐ Kin
- ☐ Other professionals (e.g. teacher, provider, clergy)

_____

TOP ASSESSMENT

COMPLETED BY ☐ Clinician - Date: _____

JUSTIFICATION

(see form on next page)

QUALIFICATION for QRTP *(must check one)*

- ☐ The needs of this youth CAN be met with family members OR through placement in a foster family home. The needs of
- ☐ this youth CAN NOT be met with family members OR through placement in a foster family home.

PREFERENCE & RECOMMENDATION DISCREPANCY

If the placement preference of the family, youth, and permanency team are NOT the placement setting (level of care, NOT site specific) recommended by the assessing clinician, explain the reasoning here:

CLINICIAN SIGNATURE _____ **DATE** _____

JUSTIFICATION

Short-term and long-term mental and behavioral health goals of youth:

Reasons these goals can NOT be met in family setting (least restrictive setting consistent with goals):