

Alameda County Behavioral Health Care Services (ACBHCS)
Short-Term Residential Therapeutic Program (STRTP)
ADMISSION STATEMENT

Client's Name:**Client's Pronouns:****Case #:****STRTP Name:****Intake Date:**

The Admission Statement is to be completed by the Head of Service or acting Head of Service within five (5) days of a child/youth's arrival to the STRTP.

1. Head of Service has read the child's Mental Health Assessment? **Yes** **No**
2. Head of Service has read the child's referral documentation? **Yes** **No**
3. Head of Service has considered the child's needs and safety? **Yes** **No**
4. Head of Service has considered the needs and safety of the other children placed at the STRTP named above? **Yes** **No**
5. Head of Service affirms that the child meets criteria for admission established in California Welfare Institutions Code section 11462.01(b): *Child must meet all three criteria for admission to a STRTP.*

a. Does the child require inpatient care in a licensed health facility (i.e. inpatient psychiatric hospitalization)? *If a child requires inpatient care they are not eligible for placement in a STRTP.*

Does not require inpatient care

Requires inpatient care

If checked, describe all clinically significant risk factors observed/identified.

Client referred to (include name and location of facility):

Date of referral:

b. The child has been assessed as requiring the level of services provided in a STRTP in order to maintain the safety and well-being of the child or others due to behaviors, including those resulting from traumas, that render the child or those around the child unsafe or at risk of harm, or that prevent the effective delivery of needed services and supports provided in the child's own

home or in other family settings, such as with a relative, guardian, foster family, resource family, or adoptive family? Yes No

c. The child has been assessed as having a commonality of needs with the other children in the STRTP? Yes No

6. And the child meets at least one of the following conditions (the child may meet more than one):

a. The child has been assessed as meeting Medical Necessity criteria for Medi-Cal Specialty Mental Health Services? Yes No N/A

b. The child has been assessed as Seriously Emotionally Disturbed as defined in subdivision (a) of section 5600.3? Yes No N/A

c. The child requires emergency placement in a STRTP prior to Interagency Placement Committee approval pursuant to paragraph (3) of subdivision (h)? Yes No

i. If the child requires emergency placement prior to Interagency Placement Committee approval, a licensed mental health professional has made a written determination within 72 hours of the child's placement that the child requires the level of services and supervision provided by the STRTP in order to meet his or her behavioral or therapeutic needs? Yes No

ii. Head of service certifies that the child or youth will be evaluated by the Interagency Placement Committee within 30 days of the emergency placement? Yes No

d. The assessment by the Interagency Placement Committee indicated the child requires the level of services provided by the STRTP in order to meet their behavioral or therapeutic needs? Yes No N/A

7. Based on these considerations, the Head of Service or acting Head of Service affirms that the child meets criteria for admission into the STRTP and admittance is appropriate? Yes No

SIGNATURE

Signature of Head of Service Accepting the Assessment:

_____ **Date:** _____

Printed Name:

_____ **Staff ID Number:** _____

Client Name:

Case #:

Program RU: