CRP-7
R. 07/22
922 KAR 1:360

CRP USE ONLY:	
CURRENT ALP DUE DATE	

Children's Review Program (CRP)

Application for Level of Care Payment (ALP)

Directions: ***Complete each section in full and submit the completed form to the Children's Review Program and the child's DCBS worker. Failure to complete this form in full will result in a delayed level of care.***

A. CHILD IDENTIFYING INFORMATION

Child's Name (Last, First)	Preferred Name	D.O.B.	Social Security #	Date of Admission
Biological Sex	**Gender Identity**	**Sexual Orientation**	**Height**	**Weight**
☐M ☐ F				

B. SERVICE PROVIDER INFORMATION

Agency		Program/Office Name		
Person Completing Form	**Date Completed**	**Telephone**	**Ext.**	**Email**

Service Dates Covered by Report					
Reporting Period Beginning			**Reporting Period Ending**		
Month	**Day**	**Year**	**Month**	**Day**	**Year**

FOSTER CARE ONLY ☐ NA
Current Foster Family (Include First & Last Name)

If there have been any changes in foster home placement during this review period, including respite, specify below. ☐ **NA**
Please provide a brief explanation for a placement move.

Reason for Move	From (Name of Foster Family)	To (Name of Foster Family)	Date of Move

C. CHILD'S SSW INFORMATION

State Worker's (First & Last Name)	County

D. CHILD STRENGTHS/PROGRESS

1	Identify this child's strengths/interests based upon the program's assessment.
2	**Please attach the following:** ☐ Current Treatment Plan or Document Summarizing Treatment Progress ☐ CANS ☐ Comprehensive Assessment/Biopsychosocial Assessment (For Initial ALP completed by submitting program)

E. RISK BEHAVIORS ☐ NA

Identify any significant behavioral issues and complete the following information for each applicable behavior that has occurred during this reporting period. Note if legal charges were filed or medical attention was sought as a result of the incident. ***Do not report historical incidents (prior to this review period), provide duplicate information, or use terms such as "ongoing" as a means to communicate frequency.***

N/A	Behaviors	Specific Dates of Occurrence	Details
☐	**Animal Maltreatment**		
☐	**Bullying/Intimidating Others**		
☐	**Delinquent/Criminal Behaviors/Conduct Related Issues**		
☐	**Property Destruction/Vandalization**		
☐	**Fire Setting**		
☐	**Gang Affiliation/Interest**		
☐	**Homicidal Threats/Plans**		
☐	**Non-Compliant with Treatment Services**		
☐	**Physical Aggression towards Others**		
☐	**Reckless Behaviors**		
☐	**Runaway (Only when child has left the premises)**		
☐	**Self-Injurious Behaviors**		
☐	**Sexual Behaviors**		
☐	**Substance Misuse (Exclude tobacco use; include positive drug screens.)**		
☐	**Suicidal Behaviors (e.g. attempts, ideation, threats)**		
☐	**Other:**		

F. SOCIAL & EMOTIONAL FUNCTIONING ☐ NA

Identify any significant social and emotional issues for each area identified below that has occurred during this reporting period.

NA	Issue	Details
☐	**Anger Control**	
☐	**Anxiety/Worry**	
☐	**Attachment Difficulties**	
☐	**Attention/ Impulsivity/Hyperactivity**	
☐	**Depression**	
☐	**Eating Disturbances**	
☐	**Oppositional/Defiant (Non-compliance with authority)**	
☐	**Psychosis (Thought Disorder)**	
☐	**Somatization**	
☐	**Tantrums**	
☐	**Other:**	

G. METHODS OF INTERVENTION USED DURING THIS REPORTING PERIOD ☐ NA

Complete the following for any services/interventions that occurred during the reporting period that required the child to stay in another location overnight (do not include home visits, etc.)

	Intervention	Provider	Reason	Date(s)
☐ NA	Psychiatric Hospitalization			
☐ NA	Crisis Stabilization			
☐ NA	Medical Hospitalization			
	Intervention	**Provider**	**Reason**	**Number of Times Utilized**
☐ NA	Use of Time-out (Do not include self-time-out)	NA		
☐ NA	Physical Management including assists	NA		
☐ NA	Other Physical Interventions (escorts, etc.)	NA		
☐ NA	Calling outside assistance (e.g. police, on-call agency staff)	NA		
☐ NA	Involuntary Confinement	NA		
☐ NA	Other (explain):			

H. SUPERVISION

Describe the supervision provided for this child, including caregiver to child ratio, oversight, etc.
Identify or attach the supervision plan this child currently has in place to ensure the safety of the child and others.

I. MEDICAL ISSUES ☐ NA

Describe any significant medical issues (including medically complex diagnoses) for which the child has received treatment during this reporting period and explain each condition and how caregiver time and resources were utilized.

J. MEDICATIONS ☐ NA

List the child's current medications:

#	Medication	Purpose	#	Medication	Purpose
1			6		
2			7		
3			8		
4			9		
5			10		

K. MENTAL HEALTH DIAGNOSES AND EVALUATIONS ☐ NA

1	List the child's current diagnoses based on the latest edition of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association. (Do not use codes only for the diagnosis)

2	**Is the current diagnosis different from what was listed on the previous ALP?** ☐ **YES** ☐ **NO** **If Yes, explain the reason for the change in diagnosis.**
3	**If the child has had a psychological evaluation during this reporting period, please submit it with this ALP. If this is the first time your agency is including a diagnosis of an intellectual or developmental disability for this child, include documentation supporting this diagnosis (e.g. IQ testing, IEP).**

L. TRAUMA RELATED ISSUES ☐ NA

Identify any issues related to past or current trauma that have been identified and are currently being addressed by your program. If the child has experienced or has revealed any new trauma during this reporting period, please provide details and how your program is addressing trauma in treatment.

Issue has been reported to DCBS? ☐**Y** ☐**N** **Date Reported:** ______________

Issue	Please explain how the child's trauma is currently being addressed in treatment. (Not necessary if an attached treatment plan addresses this.)

M. SERVICES PROVIDED ☐ NA

Provide details of any mental health services this child has received during this reporting period.

Service*	# Sessions	Name of Agency/ Program Providing Service	Provider Name(s)	Identify Degree & License, if applicable	QMHP 5S Programs Only
Case Management					
Individual Therapy Contracted Provider ☐ Y☐N					☐ Y ☐ N
Family Therapy Identify participating members based on their relationship to the child (e.g., adoptive mother and stepfather, biological father, siblings, aunt, foster parents):					☐ Y ☐ N
Group Therapy					☐ Y ☐ N
Psychoeducation Group Therapy					
Psychiatric (medication management)					
Substance Abuse					
Exploitation Services					
Sexual Offender Treatment					
Sexually Reactive Treatment					
Independent Living (Ages 14+)					

Other (e.g. speech, physical therapy, occupational therapy, wrap around services (ABA):					

If the child has not received the number or types of services as required by the PCC agreement or specified in the child's treatment plan, indicate the service and reason it was not provided. ☐ NA
Describe child's engagement/participation in treatment.
Have you requested and received approval for a therapeutic exception for this child? ☐ Y ☐ N **If yes, list the date of approval below:**
Specialized Programs Only (5S): If the provider is not a QMHP, please explain. ☐ NA

*Note that each session should only be counted for one service. For example, the same session cannot be counted as both a case management and an individual therapy session.

N. EDUCATION

SCHOOL NAME AND COUNTY/DISTRICT:		
Current Grade	**School Setting**	**Special Ed./Other Services Provided** ☐ Y ☐ N **If yes, please answer the questions below:**
	☐ Pre-school/Head Start ☐ Day Treatment ☐ Private School ☐ College ☐ Alternative School ☐ Vocational ☐ Public School (if residential indicate: ☐ Campus onsite ☐ Public school **offsite**) ☐ GED ☐ Vocational ☐ Other:	**Please list services provided:** **Primary disability listed on IEP:**

If the school has completed an evaluation of this child or if a new IEP or 504 plan has been developed during this reporting period, please include a copy of the report or plan.	
Describe child's functioning in each area below:	
Academic Functioning/Grades	
School Behavior	
Other (explain):	

O. DAILY LIVING/SOCIAL SKILLS

Describe the child's interactions/relationships with others as they relate to healthy boundaries and ability to develop bonds. Please list concerns with boundaries and attachments.
Provide a summary of the child's ability to maintain his/her personal hygiene/appearance and complete chores/tasks independently, as appropriate to age and developmental level.
Is the child receiving Independent Living Services? ☐ YES ☐ NO **If yes, please describe including areas of concern and strengths.**

P. DEVELOPMENTAL CONCERNS ☐ NA

Describe any developmental concerns, including issues with communication, mobility, feeding, drinking, and toileting issues. The reporter should take into account developmentally appropriate skills for child's chronological age and developmental level.

Q. PREGNANT/PARENTING YOUTH ☐ NA

Is youth currently pregnant? ☐Yes ☐No, If yes, anticipated due date: _ ________

Identify youth's children.

Child's Name	Age	Does the youth currently live with this child?	Does the youth have custody?	If the youth is not living with this child, what is the current contact or visitation plan?
		☐Yes ☐No	☐Yes ☐No	
		☐Yes ☐No	☐Yes ☐No	

Please include any current or potential pregnancy complications and services being provided to address the youth's prenatal care:
Describe this youth's current parenting responsibilities and skills, including strengths and potential risk factors. List any services related to parenting skills/classes being provided to the youth.

R. LEGAL CONSIDERATIONS ☐ NA

Describe any ongoing unresolved legal issues for this child. Please indicate any new charges, court and/or CDW involvement during this reporting period, as well as any court orders or dispositions.

S. DCBS PERMANENCY GOAL & CURRENT DISCHARGE PLAN

1	Select the child's current DCBS permanency goal. ☐ Return To Parent ☐ Adoption ☐ Legal Guardianship ☐ Permanent Relative Placement ☐ Planned Permanent Living Arrangement
2	If parental rights have been terminated during this reporting period, provide the date of termination. ☐ NA
3	Describe the services and treatment interventions that your agency is providing to support and promote this child's family connections and permanency. If no services are being provided, explain.
4	Describe the current discharge plan and indicate the reason for any change during this reporting period.
5	What is the child's projected discharge date?

T. FAMILY ENGAGEMENT & VISITATION/CONTACT INFORMATION ☐ NA

1.	Describe how your program is engaging or how your program has tried to engage with family members (e.g., parents, siblings, aunts/uncles, grandparents or any other individual in a familial like relationship with the child) to support and promote this child's connections. If no family engagement is occurring, please explain why:
2.	Identify the progress and any barriers encountered during family therapy sessions if the permanency goal is return to parent/relative.

Report any visitation, in person or virtual, by persons outside the current placement agency (e.g., DCBS/Wendy's Wonderful Kids worker, relatives, mentors, etc.) including the dates and results of the visits.

Date/Length of Visit	Name of Person Visiting with Child	Relation to Child	Location of Visit	Result of Visit (Give a brief description)

U. INDEPENDENT LIVING ☐ NA

1.	**Describe child's level of independent living skills and how the program is providing independent living support/skill training for the child.** ☐ **NA**
2.	**Identify youth's current employment and any employment the youth may have had during this reporting period. Include dates of hire and employment, position/duties, and performance level.** ☐ **NA**
3.	**For youth in independent living programs, describe this youth's current living arrangement and identify any issues or concerns.** ☐ **NA**

V. ADDITIONAL CONSIDERATIONS ☐ NA

Provide any additional information and recommendations for services.

______________________________ ______________

Signature of Agency Representative Date