SOUTH DAKOTA PRTF REFERRAL FORM
PSYCHIATRIC SERVICES UNDER 21

Please return the application and supporting documentation to the following address: Auxiliary Placement Program, Department of Social Services, 700 Governors Drive, Pierre, SD 57501-2291; or Fax # 605-773-7183; If you have questions please call the Auxiliary Placement Program @ 605-773-3448.

A. IDENTIFYING INFORMATION

Child's Name: _____ Date of Birth: _____

Gender: Male ☐; Female ☐; Medicaid eligible: Yes ☐; No ☐ Date submitted: _____

B. CHILD'S CURRENT LIVING ARRANGEMENTS (Check the appropriate box and list name of facility/center/hospital)

☐ Parent/relative/non-relative	☐ Group care center	_____
☐ Foster home	☐ Residential treatment facility	_____
☐ JDC	☐ Acute Hospital	

C. COMPLETE THIS SECTION IF REFERRAL IS BEING MADE BY DSS CPS, DOC OR TRIBAL/BIA AGENCY

Referring party: DOC ☐; CPS ☐; BIA/Tribal agency ☐ (identify agency) _____

Referring party contact information: Name: _____

Address: _____City: _____ Zip: _____

Phone: _____ Fax: _____E-mail _____

Has the child received a GED**: Yes ☐; No ☐** Has the child received a Diploma: **Yes ☐; No ☐**

****TRIBAL or BIA AGENCY REFERRAL – COMPLETE THE FOLLOWING QUESTIONS**
Name of school district where child is currently enrolled: _____
TUITION TO BE PAID BY: _____
Is the child on an IEP: Yes☐; No☐; Currently being tested for IEP ☐; Primary IEP disability:

D. COMPLETE THIS SECTION IF REFERRAL IS BEING MADE BY A PRIVATE PARTY

Referring party: Parent ☐; School ☐; Mental Health Therapist ☐; Hospital ☐; Court Svc ☐; HSC ☐; Other ☐;

Referring party contact information: _____

Phone: _____ Fax: _____ E-mail _____

Name of school district where child is currently enrolled: _____

TUITION: Is the child's school district agreeing to pay the tuition: Yes ☐; No ☐; Contacting school ☐;
Is the child on an IEP: Yes☐; No☐; Currently being tested☐; Primary IEP disability: _____
Has the child received a GED: Yes ☐; No☐ Has the child received a Diploma: Yes ☐; No☐

****If referral is being submitted by someone other than the parent / guardian please complete the following:**

Parent Name _____

Home Phone _____; Work phone: _____; Cell phone: _____

Parent Address: _____

Parent / Guardian e-mail: _____

E. FACILITY BEING REQUESTED

Name of facility: _____

Has the facility accepted the child? Yes ☐; No ☐; Still reviewing ☐; Comment _____

_____

List all other facilities you have contacted for potential admission and their responses: _____

F. PRIOR OUT OF HOME PLACEMENTS: Yes ☐; No ☐; TO INCLUDE: Psychiatric hospital; Human Services Center (HSC), residential treatment facility or group care center: If yes: list facility name, admit/discharge dates and outcome:

_____

_____

G. PRIOR COMMUNITY BASED MENTAL HEALTH TREATMENT Yes ☐; No ☐;

If yes list name and timelines of treatment: _____

_____

If no explain reason community based treatment has not been attempted: _____

H. MOST CURRENT PSYCHOLOGICAL / PSYCHIATRIC EVALUATION:

Please request that the evaluation be submitted for review.

Evaluation completed by: _____Date _____

DSM – V Diagnosis: _____

_____

Psychiatric Medications: _____

Full Scale IQ: _____

I. CURRENT BEHAVIORS WITHIN THE LAST 30 DAYS: _____

_____

_____

J. BEHAVIOR HISTORY INDICATING TIMELINES: _____

_____

I acknowledge this referral is for a determination if the child meets criteria for placement in a Psychiatric Residential Treatment Facility governed by ARSD 67:16:47. Completion of this form is not a guarantee of service or placement nor is it a commitment on my part to place my child.

_____

Parent / Guardian Signature **Date**