OCFS-5356 (12/2021)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

QUALIFIED RESIDENTIAL TREATMENT PROGRAM (QRTP)
LONG-STAYER REVIEW FORM

Directions: This form is completed and submitted by an individual authorized by the local department of social services (LDSS) commissioner or its designee at least **60** days prior to the youth's long-stayer threshold date. NOTE: "Threshold date" refers to the date in which the youth would no longer be eligible for Title IV-E reimbursement if not otherwise approved for such by the New York State Office of Children and Family Services (OCFS). This form must be sent to LSR@ocfs.ny.gov.

NOTE: Any significant changes to the youth's treatment needs during the pendency of this request must be added to the respective section on this form and submitted to the email above.

CHILD INFORMATION		
NAME (Last, First, Middle Initial)		
DATE OF BIRTH / /	CIN	
LEAD REVIEWER INFORMATION (main point of contact)		
WHO COMPLETED THE REVIEW? ☐ QUALIFIED INDIVIDUAL (QI) ☐ MDT/LOCAL REVIEW TEAM		
NAME OF LEAD REVIEWER AND TITLE/POSITION	REVIEW DATE COMPLETED / /	
EMAIL ADDRESS	PHONE NUMBER ( ) -	FAX NUMBER ( ) -
QRTP INFORMATION		
Agency and QRTP Name		QRTP VID #
Contact Name	Telephone Number ( ) -	Email
Case Manager (CM) Name		
CM Phone Number ( ) -	CM Email	
Case Planner (CP)	CP Phone Number ( ) -	

QRTP Long-Stayer Review Type		
Under 13	**13 and over**	
☐ 6-Month Consecutive ☐ 6-Month Nonconsecutive	☐ 12-Month Consecutive ☐ 18-Month Nonconsecutive	ADMISSION DATE / /

REASON FOR CONTINUED STAY
1. What unmet treatment needs have been identified that preclude discharge from the QRTP before the maximum length of stay? *(Age 13 or older, a maximum of 12 consecutive or 18 nonconsecutive months. If younger than age 13, a maximum of six consecutive or nonconsecutive months.)*
2. What specific services/action steps are needed to address the individual's treatment needs to successfully discharge the individual from the QRTP?
3. Identify the barriers and needed services/action steps?

4. Is the youth in agreement with the request for continued stay in the QRTP? ☐ Yes ☐ No

Please explain:

5. Is the parent/guardian in agreement with continued treatment in the QRTP? ☐ Yes ☐ No

Please explain:

SUPPORTING DOCUMENTATION: Please include the initial QI Assessment, the current evaluation used to recommend that the child remain in the QRTP, most recent court orders, support/treatment plan, all recent assessments/evaluations used in the local review, any pertinent incident reports, and any other documentation used by the local review team to support continued stay in a QRTP. NOTE: All documents must have been issued within one year prior to the submission of this form. Also, any documents located within CONNECTIONS sections must be noted below, complete with location, date, etc. so the OCFS reviewer can readily access them.

TYPE	DATE COMPLETED
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OTHER ELIGIBLE SERVICES: Has this child been deemed eligible for services provided by the Office for People With Developmental Disabilities or the Office of Mental Health? ☐ Yes ☐ No

TYPE	Date of Eligibility
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	/ /

ADDITIONAL/NEW INFORMATION (since initial submission):

TYPE	Date Completed
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OCFS USE ONLY

Date Received: / /	
Date Reviewed: / /	
OCFS Reviewer:	
Date Completed: / /	
Recommended Outcome:	☐ Approved ☐ Denied