PRTF Program Detail Survey

# Instructions for Completion

Please complete for each PRTF Facility operated by your organization (if facilities all provide the same services, complete one).

For each program you operate, please complete the survey based on the average number of hours per program participant. For example, if the average recipient participates in 20 hours of programming, indicate how those hours are split between the various service types and the “Other” activities listed at the bottom of the grid.

**Psychiatric Residential Treatment Facility (PRTF)** is a facility, other than a hospital, that provides inpatient psychiatric services. A PRTF provides comprehensive mental health treatment to children and adolescents who, due to mental illness or severe emotional disturbance, are in need of quality active treatment that can only be provided in a psychiatric residential treatment facility and for whom alternative, less restrictive forms of treatment have been unsuccessful or are not medically indicated.

The PRTF must ensure that the residents receives all treatment identified on the active treatment plan and any other medically necessary care required for all medical, psychological, social, behavioral and developmental aspects of the client’s situation.

**Part 1.** Please answer the following questions:

1. What is the PRTF’s name?

2. What is the PRTF’s location and address?

3. What is the PRTF NPI and State License Numbers?

4. Is the PRTF hospital-based or community-based?

5. What is the PRTF’s program capacity/number of beds?

6. Does the PRTF provide mental health only, substance abuse only, or specialty treatment? If specialty treatment, indicate type (e.g. dual-diagnosis, sex offender, etc.).

**Part 2.** Please describe the population served and include the following information:

1. Target Population

2. Criteria for admission and exclusion

3. Criteria for discharge

**Part 3.** Please provide the average number of hours provided per week for the following Treatment Components (if not provided, please indicate):

|  |  |  |
| --- | --- | --- |
|  | Total Hours per week | Additional Information  (if needed) |
| Therapuetic Treatment  |  |  |
|  Treatment Team Meetings (Physician) |  |  |
|  Treatment Team Meeting (Licensed Practitioner(s)) |  |  |
|  Nursing |  |  |
|  Individual Therapy (Licensed Practitioner(s)) |  |  |
|  Group Therapy (Licensed Practitioner(s)) |  |  |
|  Family Therapy (Licensed Practitioner(s)) |  |  |
|  Psychiatry Services |  |  |
|  Other (please specify): |  |  |
|  Other (please specify): |  |  |
|  Other (please specify): |  |  |  |

**Part 4.** When included on the active treatment plan,please indicate if the following services are provided, by and in, the facility:

|  |  |  |
| --- | --- | --- |
| **Check one:** | **Provided** | **Not Provided** |
| Occupational Therapy |  |  |  |
| Physical Therapy |  |  |  |
| Speech/Language Therapy |  |  |  |
| Laboratory Services |  |  |  |
| Transportation |  |  |  |
| Vision |  |  |  |
| Dental |  |  |  |
| Diagnostic and radiology services |  |  |  |
|  |  |  |  |

**Part 5. Please provide a description of your education program and the per diem cost:**

Education Cost: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Education Program Description \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_