Nevada Medicaid and Nevada Check Up

RTC Absence Form

Purpose: To notify Nevada Medicaid of an absence from a Residential Treatment Center (RTC) . This form is not to be used for an elopement. The Prior Authorization Data Corrrection Form (FA-29) is to be used to report an elopement.

Policy for therapeutic pass: A therapeutic home pass must be used 1) to facilitate a recipient's discharge back to their home or less restrictive setting, 2) within 90 days of the recipient's planned discharge and 3) in coordination with their discharge plan. The recipient must 1) have demonstrated a series of successful incremental day passes first and 2) be in the final phase of treatment in the RTC program *(MSM 403.8A.6a.2).*

Limitations: Three therapeutic home passes are allowed per calendar year *(MSM 403.8A.6)*.

Notification/Request Timeline:

- This form must be received at least 14 days prior to the pass being issued to the recipient if related to a therapeutic pass.
- This form must be submitted the day of the absence for any other type of absence.

Upload this request through the Provider Web Portal. **Questions?** Call: (800) 525-2395

Request Type *(please check one)*:

- ☐ Notification of a recipient's 72-hour or less therapeutic home pass
- ☐ Prior authorization request for a therapeutic home pass longer than 72 hours
- ☐ Other type of absence, provide details in "Notes" field below

NOTES:

RECIPIENT INFORMATION

Recipient Name:	Recipient ID:

FACILITY INFORMATION

Facility Name:

Facility Address:

NPI:

ABSENCE INFORMATION

Dates of Leave – From:	Time:	To:	Time:

Explain the goals and objectives for a therapeutic home pass and identify how they pertain to the recipient's discharge plan or details related to the reason for any other type of leave.

PHYSICIAN'S ORDER

Is it clinically appropriate for the recipient to travel alone? ☐ Yes ☐ No

Is there an escort? ☐ Yes ☐ No

I certify that the individual indicated above meets the requirements for therapeutic home leave if applicable.

Physician Signature: ______________________________________ **Date:** _________________

Physician Name (print/type): ____

Professional Title: ____