

## RTC Therapeutic Home Pass Form

**Purpose:** To notify Hewlett Packard Enterprise of a recipient's 72-hour or less therapeutic home pass from a Residential Treatment Center (RTC) or to request prior authorization for a therapeutic home pass longer than 72 hours.

**Policy:** 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 (*MSM 403.8A.6*).

**Fax this request to:** (866) 480-9903

**Questions? Call:** (800) 525-2395

<b>Request Type</b> ( <i>please check one</i> ):	
<input type="checkbox"/> Notification of a recipient's 72-hour or less therapeutic home pass	
<input type="checkbox"/> Prior authorization request for a therapeutic home pass longer than 72 hours	
<b>RECIPIENT INFORMATION</b>	
Recipient Name:	Recipient ID:
<b>FACILITY INFORMATION</b>	
Facility Name:	
Facility Address:	
NPI:	
<b>THERAPEUTIC HOME PASS INFORMATION</b>	
Dates of Leave – From:	To:
Explain the goals and objectives for this therapeutic home pass and identify how they pertain to the recipient's discharge plan.	
<b>PHYSICIAN'S ORDER</b>	
Is it clinically appropriate for the recipient to travel alone? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is there an escort? <input type="checkbox"/> Yes <input type="checkbox"/> No	
I certify that the individual indicated above meets the requirements for therapeutic home leave.	
<b>Physician Signature:</b> _____	<b>Date:</b> _____
Physician Name (print/type): _____	
Professional Title: _____	