VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

VERMONT MEDICAID CHILD/ADOLESCENT INPATIENT ADMISSION NOTIFICATION FORM

The following information and justification must be provided by the Designated Agency/SSA conducting the screening. Please submit to the **Department of Vermont Health Access,**
(Toll-free fax #855-275-1212) within 24 hours of the inpatient admission.

Admission date: _____ Facility: _____
Child/Adolescent name: _____
Address: _____
Medicaid Unique ID: _____ Date of Birth: _____
Parent/Guardian name: _____
Parent/Guardian consent on file? ____ Yes ____ No Parent/Guardian phone number: _____
DCF custody? ☐ Yes ☐ No If yes, name of assigned social worker, district, and telephone number:
_____
DA/SSA active client? ☐ Yes ☐ No Referral Source: _____
Screener Name: _____ Agency: _____
Status: ☐ Voluntary ☐ Involuntary

Alternatives considered:	**Status of referral:** (denied, not appropriate, wait list)	If denied name of the individual issuing the denial and rational:
HC Jarrett House 802-488-6000		
NFI HDP (south) 802-258-2173		
NFI HDP (north) 802-658-2004		
Kinship Care		
In-home support		
Other (please specify)		

If no alternatives were considered please explain in narrative below:

Assessment (clinical justification satisfying criteria for hospitalization) please address the following in narrative:

- Evidence of mental illness (previous diagnosis or need for diagnosis clarity)
- Description of current and recent behavior(s) and level of dangerousness to self or others (i.e., violence, suicide plan and means, disorganized thinking and/or functioning)
- Medical information (physical health, medications and compliance, complicating medical factors or medication issues)
- Evidence of failure or unmanageability at less intensive levels of care (family functioning, strengths and availability of support systems such as school and community, previous and current mental health treatment)

Please share information that you have gathered from your own personal observations and/or as reliably reported to you by another person which led you to believe that the proposed patient is in need of inpatient hospitalization for treatment of a mental illness. If this information is contained in another document that has been completed at the time of this admission, that documentation can be faxed with the form with “see attached” written in this space.

Name: _____ Agency: _____

Phone: _____