Residential Community Reintegration Request Form

arkansas total care

Section 1: Member Information

Member Name:	Date of Birth:
Medicaid ID/Insurance #:	Date of Request:
Request Type: ☐ Initial Admission ☐ Continued Stay	

Section 2: Provider Information

Provider Name, Credentials:	Facility Name:
Facility NPI/TID #:	Contact Person:
Phone Number:	Email Address:

Section 3: Clinical Documentation Checklist

Initial Admission Request

☐ Treatment plan signed by a licensed mental health professional OR recommendation letter from a licensed mental health professional (if treatment plan is unavailable)

☐ Mental health evaluation (if completed)

☐ Educational services plan (on-campus or off-campus per Arkansas Department of Education guidelines)

☐ Service frequency plan including:

- ☐ Up to 90 units requested (1 unit = 1 day)
- ☐ Minimum of 15 treatment hours/week
- ☐ Up to 5 hours may be community enrichment activities
- ☐ At least 3 hours/encounters per week by a licensed mental health professional
- ☐ At least 1 hour/encounter per week individual therapy
- ☐ Minimum of 1 encounter/month by MD/APRN/prescriber

Continued Stay Request

☐ Meets all initial admission criteria

☐ Most recent treatment plan

☐ Progress notes from the last 30 days (including all therapy notes)

☐ Psychotherapy documentation

Section 4: Clinical Summary

Provide a brief summary of the member's current clinical status, progress, and justification for admission or continued stay: