Qualified Residential Treatment Program (QRTP)
Extended Placement Request

SECTION A. To be completed by the requesting agency. **(The recommendations from the multidisciplinary team staffing conducted within the last 60 calendar days and the most recent qualifying assessment shall be submitted with this approval request to the RMD or DCF designee.)**

Date:

Name of Requestor: Requesting Agency:

Child's Name: DOB/Age: FSFN Case ID:

All Begin & End Dates of Placement in a QRTP:

QRTP Name (current placement):

Address:

An extension for placement is requested due to (select one):

☐ Youth is under 13 years old in a QRTP placement for 6 months (consecutive or non-consecutive)

☐ Youth is age 13-17 years old in a QRTP placement for 12 consecutive months or 18 non-consecutive months.

SECTION B. To be completed by the RMD or DCF designee.

SAMH Consultation Completed by: _____ Date: _____

☐ Extension Granted ☐ Extension Denied (explanation required)

Comments:_____
_____

_____ _____ _____
RMD or DCF Designee Name Signature Date