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| **DMCPS Higher Level of Care Request Form**This document is to be used to request a higher level of care for a child/youth served by DMCPS or its contracted agencies. Complete the form in its entirety and the form email to DCFDMCPSHLOCrequest@Wisconsin.gov. Ongoing Services Section (OSS) will review and issue a response within 24 business hours. Any questions should be directed to the OSS team at: DCFDMCPSOngoingServicesSection@Wisconsin.gov.  |
| Date of Request      | Is this an Emergency Request?     | Date Response Needed By      |
| Family eWiSACWIS #      | Child Name       | Child’s DOB      | Child’s eWiSACWIS #       |
| Name – Case Manger      | Name – Supervisor      | Name – Program Manager/Director      |
| HLOC Requested*(select from the following list: TFC, Group Home, In-State RCC, Wrap Assessment)*       |
| Current Placement Type:      | Start Date of Placement**:**      | Reason for COP from this Placement:      |
| Provide a brief placement summary for the child      |
| Describe what efforts have been made to maintain this child at the current level of care, and why a higher level of care is being requested      |
| Describe services that are in place to serve the child, and why there are no other services available to meet the needs of the child other than a higher level of care      |
| Describe any current physical or mental health diagnosis(es) or concerns, prescribed medications, and any physical or behavioral health condition, specific crisis/emergency management plans and the child’s current placement stability      |
| **To be completed by DMCPS Ongoing Services Section**OSS Name:       | **Decision Date***Insert Date*  |
| **HLOC Determination**[ ]  Approved [ ]  Denied [ ]  Staffing Required: *Insert Date* | **Approval Expiration Date:** 90 days from above date, unless otherwise specified |
| **COMMENTS** *(OSS will include any subsequent Staffing determinations here)*      |