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| **DEPARTMENT OF HEALTH SERVICES**  Division of Care and Treatment Services  F-02596 (02/2020) | | | | |  | | **STATE OF WISCONSIN**  Wis. Stat. § 51.042 | | | | | | |
|  | | | | |  | Direct questions to: [dhsdctsycsf@dhs.wisconsin.gov](mailto:dhsdctsycsf@dhs.wisconsin.gov) | | | | | | | |
| **YOUTH CRISIS STABILIZATION FACILITIES**  **EXTENSION OF STAY AUTHORIZATION** | | | | | | | | | | | | | |
| Completion of this form is voluntary; however, failure to complete this form will result in a denial for an extension of stay in the YCSF. All the information requested on this form needs to be submitted as part of the approval process. Personally identifiable information is collected on this form for the sole purpose of identifying the program participant and processing the request, and will not be used for any other purpose.  This form is intended to be used by YCSF providers seeking authorization for a youth’s extended stay (over 30 days) in a Youth Crisis Stabilization Facility (YCSF). Authorization must be obtained from the Department of Health Services, Division of Care and Treatment Services (DHS-DCTS).  **NOTE:** Per [Wis. Admin. Code § DHS 50.06 (2)](https://docs.legis.wisconsin.gov/code/register/2019/767A2/register/emr/emr1922_rule_text/emr1922_rule_text) if a youth requires stabilization longer than a 30-day period, approval from the DHS‑DCTS must be obtained. | | | | | | | | | | | | | |
| Organization Name | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| Street Address | | | | City | | | | | | State | | | Zip Code |
|  | | | |  | | | | | |  | | |  |
| Contact Name | | | | Title | | | | | | Phone Number | | | |
|  | | | |  | | | | | |  | | | |
| Contact Email | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| Youth’s Name | | | | | | | | | Age | | Number of Days in YCSF | | |
|  | | | | | | | | |  | |  | | |
| Legal Guardian’s Name | | | | | | | | | Relationship to Youth | | | | |
|  | | | | | | | | |  | | | | |
| The following narratives and responses to questions are required. Approval for a youth to remain in a YCSF will be made based on the narratives and answers provided in this form.  Upon completion and submission of this form, a representative from the DHS-DCTS will review and approve or deny the request for stabilization beyond the 30 day period in a Youth Crisis Stabilization Facility. If approved, DHS-DCTS will authorize a specific amount of days based on the information provided in this form. | | | | | | | | | | | | | |
| **Complete the Following Questions by Providing a Response** | | | | | | | | | | | | | |
| 1. Provide a summary of the treatment the youth received in the YCSF. What benefit will the youth receive from additional days in the YCSF? | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| 1. How many additional days does the organization estimate the youth will remain in the YCSF? | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| 1. Was the admission in the YCSF pursuant [Wis. Stat. § 51.20 (13) (a) 3](https://docs.legis.wisconsin.gov/statutes/statutes/51/20/13/a/3) or [Wis. Stat. § 51.13](https://docs.legis.wisconsin.gov/statutes/statutes/51/13)? | | | | | | | | | | | | | |
|  | Yes  No; Voluntary | | | | | | | | | | | | |
| 1. Have the parents/legal representative and youth consented to additional days in the YCSF? | | | | | | | | | | | | | |
|  | Parents/Legal Representative  Yes  No | | Youth  Yes  No | | | | | | | | | | |
| 1. Why does the youth need additional days in the Youth Crisis Stabilization Facility? What is the discharge plan for the youth to return to his/her/their community? | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **SIGNATURE** – Organization Representative | | | | | | | | Date Signed | | | | Date Submitted | |
|  | | | | | | | |  | | | |  | |
| Organization’s Comments or Concerns | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| Approved | | **SIGNATURE** – DCTS Representative | | | | | | | | | | Date Signed | |
| Yes  No | |  | | | | | | | | | |  | |
| Comments | | | | | | | | | | Authorized Number of Days | | | |
|  | | | | | | | | | |  | | | |
| Please send this document via **secure email** or via mail to**:**  Email: [dhsdctsycsf@dhs.wisconsin.gov](mailto:dhsdctsycsf@dhs.wisconsin.gov)  Mailing Address: Department of Health Services  Division of Care and Treatment Services  Attn: Youth Crisis Stabilization Facilities Room 951  PO Box 7851  Madison, WI 53707 | | | | | | | | | | | | | |