MH 729
Revised 3/8/19

KATIE A. SUBCLASS MEMBERSHIP VERIFICATION

Instructions: This form should be completed in the following situations:

(1) Upon intake for any client under 21 years of age who meets Medi-Cal Medical Necessity criteria and has an open child welfare case;

(2) Throughout treatment upon opening of a new child welfare case; and/or

(3) When a change in treatment is warranted (i.e. when one of the below programs/services becomes applicable)**.**

A Client meets Katie A. Subclass membership if he/she is currently in or being considered for one or more of the following programs/services:	
☐ **Yes** ☐ **No**	Wraparound
☐ **Yes** ☐ **No**	Therapeutic Foster Care (TFC)
☐ **Yes** ☐ **No**	Therapeutic Behavioral Services (TBS)
☐ **Yes** ☐ **No**	Crisis Stabilization
☐ **Yes** ☐ **No**	Crisis Intervention
☐ **Yes** ☐ **No**	Specialized Foster Care D-Rate due to behavioral needs
☐ **Yes** ☐ **No**	Foster Care Group Home (RCL 10 or above)
☐ **Yes** ☐ **No**	Short-Term Residential Therapeutic Program (STRTP)
☐ **Yes** ☐ **No**	24-Hour Mental Health Treatment Facility (CTF or PHF)
☐ **Yes** ☐ **No**	Inpatient Mental Health
☐ **Yes** ☐ **No**	Has experienced 3 or more placements within 24 months due to behavioral health needs

☐ **Client meets Katie A. Subclass Criteria**
(DPI segment must be included on all claims)

☐ **Client does not meet Katie A Subclass Criteria**

_____ _____ _____
Staff (Print Name) **Signature & Discipline/Title** **Date**

☐ **Client no longer meets one or more of the above criteria as of:** _____
Date

**A client no longer meets Katie A. Subclass Membership if the client no longer has a child welfare case and/or is no longer in or being considered for any of the above listed programs/services*

_____ _____ _____
Staff (Print Name) **Signature & Discipline/Title** **Date**

Name: **ID#:**

Agency: **Provider #:**

Los Angeles County – Department of Mental Health

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