

# 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

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name:

ID#:

Agency:

Provider #:

Los Angeles County – Department of Mental Health

## Katie A. Subclass Membership Verification Form