CFS 906-5
Rev 8/2007

State of Illinois
Department Of Children and Family Services

Residential Care Bed Hold Payment Request

DATE OF ABSENCE ___/___/_____

REQUEST PERIOD: ☐ **Initial** Bed Hold Episode ☐ **Consecutive** Approved Bed Hold Episode
(Attach decision memorandum from Deputy Director)

TYPE OF ABSENCE: ☐ Run ☐ Detention ☐ Psych Hospital ☐ Medical Hospital ☐ Alcohol & Drug Treatment

Child Name _____ I.D. No. _____

Provider Name _____ Provider No. _____

Staffing Held Date: ___/___/_____ Staffing Results: ☐ INTENT **TO** RETURN ☐ **NO** INTENT TO RETURN

	ACTIVITES	ACTIVITIES	ACTIVITIES	ACTIVITIES
Day 1	_____ _____ _____	Day 9 _____ _____ _____	Day 17 _____ _____ _____	Day 25 _____ _____ _____
Day 2	_____ _____ _____	Day 10 _____ _____ _____	Day 18 _____ _____ _____	Day 26 _____ _____ _____
Day 3	_____ _____ _____	Day 11 _____ _____ _____	Day 19 _____ _____ _____	Day 27 _____ _____ _____
Day 4	_____ _____ _____	Day 12 _____ _____ _____	Day 20 _____ _____ _____	Day 28 _____ _____ _____
Day 5	_____ _____ _____	Day 13 _____ _____ _____	Day 21 _____ _____ _____	Day 29 _____ _____ _____
Day 6	_____ _____ _____	Day 14 _____ _____ _____	Day 22 _____ _____ _____	Day 30 _____ _____ _____
Day 7	_____ _____ _____	Day 15 _____ _____ _____	Day 23 _____ _____ _____	
Day 8	_____ _____ _____	Day 16 _____ _____ _____	Day 24 _____ _____ _____	

List of Valid Caseworker Activities

Enter the number of each service provided for each day. Services provided must be documented in the treatment record for the child.

1 Mental Health Assessment
2 Treatment Plan Develop, Review & Mod
3 Crisis Intervention
4 Therapy/Counseling, Individual
5 Therapy/Counseling, Family
6 Mental Health Case Management
7 Client-Centered Consultation : Casemanagement
8 Transition Linkage & Aftercare: Casemanagement
9 Community Support - Individual
10 Community Support - Group
11 Community Support - Residential
12 Therapy/Counseling - Group

_____ ID _____ Date ____/____/_____ ____/____/____
Caseworker (Required) RG SI FD

_____ ID _____ Date ____/____/_____ ____/____/____
Supervisor (Required) RG SI FD

(Note: Signature of Caseworker and Supervisor are required for all requests **except** when the child is **not** to return to the Previous Placement. Either signature is required for that request.)

Copies to – Case File