Children and Family Treatment Supports Services Continuing Authorization Request Form

<u>Instructions</u>: If the MCO is requesting concurrent review before the fourth visit; the CFTSS provider can complete this form when requesting continuation of services. If the services are deemed appropriate, then a minimum of 30 visits will be authorized. Concurrent review will be completed as applicable after the first concurrent authorization. A telephonic request can be completed if necessary. *Please note: No prior authorization is required for CFTSS. Providers should refer to MCO-specific guidance regarding notification requirements prior to service delivery.* This form is NOT required to be used, but a sample template to capture the necessary information to substantiate medical necessity.

Member Information:			
Member name:	Member DOB:		
Member ID:	Enrolled in HCBS services (if known) Yes No		
Guardian:	Contact number:		
Member Address:			
Health home: (if applicable)			
Health Home Care Manager (if applicable):			
Managed Care Plan:	MMCP Case Manager (if known):		
MMCP Contact number/extension:	Email:		
Primary Care provider (if known):	Contact #:		
Children and Family Treatment Support Services Requested			
Please select each service for which authorization is being requested (more than one can be selected for one form):			
🗌 Other Licensed Practitioner 🗌 Community Psychiatric Supports & Treatment 🗌 Psychosocial Rehabilitation			
Family Peer Support Services Vouth Peer Support & Training Crisis Intervention			
CFTSS Provider Information:			
Provider/Agency name:	Tax ID #:		
Provider Address:			
Contact Person:	Indicate best time to call:		
Email Address:	Contact Number:		
Alternate Contact (example, Supervisor):			
Contact Number:	Email Address:		
Email Address:			
Date of initial appointment:			

Requested CFTSS:		
Start date (1 st service visit):	Frequency (# services per wk.):	Intensity (hrs. per service):
Duration (e.g. 3 mos.):		
Diagnosis (if applicable):		
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Goal(s) for Service:

Clearly identify the child's goal(s) and list specific objectives for the period of requested services. Objectives should be results-oriented, measurable steps toward the overall goal that can be achieved within the requested period of services.

Objective: _____

Identify continued stay criteria by providing evidence of the following:

- Describe the child's involvement towards their service goals and how they continue to meet criteria for services
- Describe progress the child has made towards their service goals. If no progress has occurred, identify changes that will be made to help the child meet their service goals.
- Family involvement, if any
- Identify why an alternate service would not meet the child's needs

Requested CFTSS:		
Start date (1 st service visit):	_ Frequency (# services per wk.):	Intensity (hrs. per service):
Duration (e.g. 3 mos.):		
Diagnosis (if applicable):		

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Provider Attestation				
I attest that the services listed above have been recommended by myself or a qualified LPHA to ameliorate behaviors related to or to prevent further development of a behavioral health diagnosis and an appropriate treatment plan has been developed by a qualified practitioner.				
Signature:	Date:			
Name (please print):	Title:			