Children and Family Treatment Supports Services Continuing Authorization Request Form

Instructions: 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 ☐ Youth 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 (1st service visit): _____ Frequency (# services per wk.): _____Intensity (hrs. per service): _____
Duration (e.g. 3 mos.): _____
Diagnosis (if applicable): _____

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 (1st service visit): ____ Frequency (# services per wk.): ____Intensity (hrs. per service): ____
Duration (e.g. 3 mos.): ____
Diagnosis (if applicable): _____

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 goal.
- Family involvement, if any
- Identify why an alternate service would not meet the child's needs

_____
_____
_____
_____
_____
_____

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: _____