COMMUNITY CARE
Behavioral Health Organization

Family Based Mental Health Services Pre-certification Request
All Counties

Facility Information

This section to be completed by Family Based provider only.

Date Referral Received: *(mm/dd/yyyy)* _____ Family-Based Provider: _____

Contact Person: _____ Phone: *(no dashes)* _____

Fax: *(no dashes)* _____

Referral Information

This section to be completed by referral source.

Date Referral Sent: *(mm/dd/yyyy)* _____ Referral Source/Contact Person: _____ Phone: _____ *(no dashes)*

Identifying Information

Member Name: (First): _____ (Last): _____

Chosen Name: _____ Pronouns: _____

MA ID #: _____ Date of Birth: *(mm/dd/yyyy)* _____ Age: ____ Phone: *(no dashes)* _____

Address: _____ Insurance: _____

County: _____

Family Information

Legal Guardian(s) / Relationship: _____ Address: _____ Phone: _____ *(no dashes)*

Guardian/Parent: _____ Address: _____ Phone: _____ *(no dashes)*

Guardian/Parent: _____ Address: _____ Phone: _____ *(no dashes)*

Others Living in Household (please include name, age, and relationship to child)

1. _____
2. _____
3. _____

Immediate Relatives Not Living in Household (please include name, age, and relationship to child)

1. _____
2. _____
3. _____

Prescription Information

Of note, prescription for FBMHS must be sent with this form.

Prescriber's Name: _____ Phone: _____ *(no dashes)* Date of Prescription: _____ *(mm/dd/yyyy)*

Reason for Referral

- ☐ Suicidal/homicidal ideation/self-injurious behavior
- ☐ Psychosocial functional impairment
- ☐ Thought impairment
- ☐ Psycho-physiological condition (i.e. bulimia, anorexia nervosa)
- ☐ Psychomotor retardation or excitation
- ☐ Cognitive impairment
- ☐ Affection/function impairment (i.e. withdrawn, reclusive, labile)
- ☐ Impulsivity and/or aggression
- ☐ Substance use

Please provide information on: severity and frequency of psychiatric symptoms, behavior problems, family issues and significant psychosocial stressors that are affecting child/family functioning; current services and discharge status; history of treatment engagement.

Risk

Is child at risk for out-of-home placement? ◯ Yes ◯ No If yes, explain why:

What type of out-of-home placement?

◯ Psychiatric Hospitalization ◯ RTF ◯ Foster Care ◯ Juvenile Court Placement ◯ Other *(Please Specify)* _____

Does the child pose a risk to the safety of self or others? ◯ Yes ◯ No If yes, explain why:

Is the child able to be managed safely outside of an inpatient setting or psychiatric residential treatment facility?

Is FBMHS needed as a step-down because the child is returning home from an out-of-home placement?

Diagnostic Information

Psychiatrist / Psychologist: _____ Phone: *(no dashes)*

Current Medications: _____

Please include a primary behavioral health diagnosis. Other diagnoses may be included.

Behavioral Health _____

Behavioral Health _____

Behavioral Health _____

Diagnostic Information

Medical Conditions/ Physical Health Issues _____

Medical Conditions/ Physical Health Issues _____

Medical Conditions/ Physical Health Issues _____

Physical Health Information

Primary Care Physician: _____ Has child had a physical examination within the past 12 months? ◯ Yes ◯ No Date: _____ *(mm/dd/yyyy)*

Does the child have a physical health condition that interferes with activities of daily living? ◯ Yes ◯ No Height: ___ ft ___ in Weight: ___ lb

Does the child have Commercial Primary? ◯ Yes ◯ No Does the child's physical health condition influence their behavioral disorder? ◯ Yes ◯ No

Note the plans to address these physical health needs or the current treatment already in place:

Education

School: _____ Grade: _____ School Contact: _____

Educational Placement: _____ Phone: *(no dashes)* _____

Behavioral Health History

Previous and Current Treatment	Dates *(mm/dd/yyyy)*	Facility/Provider	Effectiveness *(please comment)*
☐ Case Management *(please specify)* _____	Start: End:		
☐ Outpatient	Start: End:		
☐ Partial	Start: End:		
☐ IBHS	Start: End:		
☐ Family-Based	Start: End:		
☐ Psychiatric hospitalization	Start: End:		

☐ Residential Treatment Facility	Start: End:		
☐ Other *(please specify)* _____	Start: End:		

Other Relevant History / Information / Service Involvement

☐ SUD Contact: _____ Phone: _____ Comments: _____

☐ IDD Contact: _____ Phone: _____ Comments: _____

☐ Other Contact: _____ Phone: _____ Comments: _____

Is Children, Youth, and Family Services involved? ◯ Yes ◯ No

In what capacity is Children, Youth, and Family Services involved?

☐ General Protective Services (GPS) ☐ Intake/Investigation ☐ Temporary legal custody
☐ Health care decision making ☐ Adjudicated Dependent - Home ☐ Adjudicated Dependent - Placement
☐ Termination of Parental Rights (TPR) ☐ Other _____

Is there a history of Children, Youth, and Family Services involvement? ◯ Yes ◯ No

In what capacity was Children, Youth, and Family Services involved?

☐ General Protective Services (GPS) ☐ Intake/Investigation ☐ Temporary legal custody
☐ Health care decision making ☐ Adjudicated Dependent - Home ☐ Adjudicated Dependent - Placement
☐ Termination of Parental Rights (TPR) ☐ Other _____

Is Juvenile Justice Services involved? ◯ Yes ◯ No

In what capacity is Juvenile Justice Services involved?

☐ Court-Ordered Treatment ☐ Probation ☐ Adjudicated Delinquent
☐ Awaiting delinquency proceeding ☐ Other _____

Is there a history of Juvenile Justice Services? ◯ Yes ◯ No

In what capacity was Juvenile Justice Services involved?

☐ Court-Ordered Treatment ☐ Probation ☐ Adjudicated Delinquent
☐ Awaiting delinquency proceeding ☐ Other _____

Child and Family Strengths

Include attributes, talents, relationship skills, natural and community supports.

Child:

Family:

Other Pertinent Information

MISA screen was completed on: *(mm/dd/yyyy)* ____ Does child use substances? ◯ Yes ◯ No Last Use: ____

Is there a substance use diagnosis? ◯ Yes ◯ No What is the plan for treatment? ____

Tobacco screen completed on: *(mm/dd/yyyy)* ____

Tobacco user? ◯ Yes ◯ No

Has cessation been discussed? ◯ Yes ◯ No

Is member interested in a referral for tobacco cessation?

☐ Referred to Tobacco Cessation Therapist/Program

☐ Referred to Quit Line

Domestic Violence screen was completed on: *(mm/dd/yyyy)* ____

Is the child a **witness** to domestic violence in the home? Currently: ◯ Yes ◯ No By History: ◯ Yes ◯ No

Is the child a **victim** to domestic violence in the home? Currently: ◯ Yes ◯ No By History: ◯ Yes ◯ No

Was a referral made for treatment? ◯ Yes ◯ No To Whom? ____

Performance Outcome Management System

Priority Population Grouping	Independence of Living Status	
◯ Child or Adolescent with EPSDT plan	◯ C&A Alone	◯ C&A in Supervised Setting
◯ Child or Adolescent at risk for EPSDT plan	◯ C&A in Family Setting	◯ C&A in Restrictive Setting
◯ Child or Adolescent in treatment (no EPSDT risk)	◯ C&A Living Dependently	◯ C&A Homeless

Vocational/Educational Status		
◯ C&A Competitive Employment	◯ C&A Meaningful Activity	◯ C&A Training/Education
◯ C&A No Activity	◯ C&A Work Program	

Child/Adolescent Data

School Attendance	School Performance	School Behavior	Source of School Information
◯ Regular Attendance	◯ Above Average	◯ No behavior problems	◯ Child
◯ Sporadic attendance	◯ Average	◯ Occasional behavior problems	◯ Parent/Guardian
◯ Enrolled but rarely attends	◯ Below Average	◯ Constant behavior problems	◯ School system
◯ Dropped out this quarter	◯ Failing		◯ Interagency meeting
◯ Dropped out in a prior quarter			◯ Other
◯ Unknown ◯ N/A	◯ Unknown ◯ N/A	◯ Unknown ◯ N/A	◯ Unknown ◯ N/A

Complete Precert Packet must include:(please check that the following are included)

☐ Precert Form ☐ Family Based Prescription Letter ☐ Referral Tracking Form (if applicable)

Start Date for Family-Based Services: *(mm/dd/yyyy)* ____

If partial or full denial of this request is being considered, do you want to consult with the Professional Advisor (PA) making the decision? ◯ Yes ◯ No

If yes, please list a daytime business phone number at which you can be reached: *(no dashes)* ____