

Family Based Mental Health Services Web Precert Form

IDENTIFYING INFORMATION			
Child's Name:	Date of Birth/Age:	Gender:	Race:
Address:	Phone:	Social Security Number:	
County:	Insurance:	MA Number:	

FACILITY INFORMATION *(This section to be completed by family based provider only)*

Date: _____ Family Based Provider: H.O.P.E. Network, CRCSI

Contact Person: Jill Y. White, MA Phone: 724.438.5520

REFERRAL INFORMATION

Referral Source: _____ Contact Person: _____ Phone: _____

Psychiatrist / Psychologist: _____ Phone: _____

Current Mental Health Diagnosis	
Axis I	
Axis II	
Axis III	
Axis IV	
Axis V	

Outpatient MH treatment is inappropriate or insufficient to meet the needs of the CHILD because:

REASON FOR REFERRAL

<input type="checkbox"/> Suicidal/homicidal ideation/self-injurious behavior <input type="checkbox"/> Impulsivity and/or aggression <input type="checkbox"/> Affection/function impairment (i.e. withdrawn, reclusive, labile) <input type="checkbox"/> Psychomotor retardation or excitation <input type="checkbox"/> Trauma	<input type="checkbox"/> Psychosocial functional impairment <input type="checkbox"/> Thought impairment <input type="checkbox"/> Cognitive impairment <input type="checkbox"/> Substance abuse <input type="checkbox"/> SED*** If present, describe in detail below:
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<input type="checkbox"/> Psycho-physiological condition (i.e. bulimia, anorexia nervosa)		
RISK		
Is child at risk for out-of-home placement? <input type="checkbox"/> YES <input type="checkbox"/> NO Has the child ever been placed out of the home? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, explain:		At risk for what type of out-of-home placement? <input type="checkbox"/> Psychiatric hospitalization <input type="checkbox"/> RTF <input type="checkbox"/> Foster Care <input type="checkbox"/> Juvenile Court Placement <input type="checkbox"/> Other (please specify)
FAMILY INFORMATION		
Legal Guardian(s) / Relationship:	Biological Mother:	Biological Father:
Address:	Address:	Address:
Phone:	Phone:	Phone:
Others Living in Household <i>(Please include name, age, and relationship to child)</i>		Immediate Relatives NOT Living in Household <i>(Please include name, age, and relationship to child)</i>
Member's Risk to Self: <input type="checkbox"/> 0 (None) <input type="checkbox"/> 1 (Mild or Mildly Incapacitating) <input type="checkbox"/> 2 Moderate or Moderately Incapacitating <input type="checkbox"/> 3 (Severe or Severely Incapacitating) <input type="checkbox"/> NA (Not Assessed)		Member's Risk to Others: <input type="checkbox"/> 0 (None) <input type="checkbox"/> 1 (Mild or Mildly Incapacitating) <input type="checkbox"/> 2 Moderate or Moderately Incapacitating <input type="checkbox"/> 3 (Severe or Severely Incapacitating) <input type="checkbox"/> NA (Not Assessed)
Describe detailed information regarding psychiatric symptoms / behavior problems / significant psychosocial stressors that may interfere with child / family function in the home:		
Previous and Current Mental Health Treatment	Dates	Facility/Provider
<input type="checkbox"/> ICM/RC or Blended Case Management		
<input type="checkbox"/> Outpatient		
<input type="checkbox"/> Partial		
<input type="checkbox"/> BHRS (wraparound)		
<input type="checkbox"/> Family Based		
<input type="checkbox"/> Psychiatric Hospitalization		
<input type="checkbox"/> Residential Treatment Facility or CRR		
<input type="checkbox"/> Other		

CURRENT MEDICATION		
Name	Dose	Frequency
Any medical concerns:		
Has the child had a physical examination in the past 12 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Has the child had psychiatric/psychological evaluation in the past 6 months?	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <i>If YES, date of eval:</i>	
Date of Best Practice Recommendation for family based mental health services: (**RECOMMENDATION FOR FB MUST BE ATTACHED**)	Prescriber / Phone:	

CHILD AND FAMILY STRENGTHS (include individual strengths, family strengths, natural supports and community linkages)
Is child returning home from an out-of-home placement and FBMS is needed as a step-down? If yes, please describe. <input type="checkbox"/> YES <input type="checkbox"/> NO

Complete Precert Packet must include: (please check that the following are included) (FBMHS PROVIDER)	
<input type="checkbox"/> Precert Form	<input type="checkbox"/> Best Practice Prescription Letter/Psychiatric or Psychological Eval.
	Start Date for Family Based Services:
Provider Signature (FBMHS USE ONLY):	Date (FBMHS USE ONLY):

AUTHORIZATION INFORMATION (FBMHS USE ONLY)
of Units Requested for 6 Weeks: 168
Date: _____ to: _____
Date of Next Review: (6 weeks from start date)

FAX COMPLETED FORM TO: 724-437-1875, Attention: Program Director