beacon health options

Family Based Mental Health Services: Pre-Cert Form

Childs Name: _____ MA ID #: _____ DOB: _____ Gender: _____

Date of Best Practice Recommendation for family based mental health services? _____

Prescriber NPI # ? _____ (**Referral instructions below)**

Outpatient MH treatment or other community based services are inappropriate or insufficient to meet the needs of the CHILD because:

Reason for Referral:

☐ Suicidal/homicidal ideation/self-injurious behavior ☐ Impulsivity and/or aggression
☐ Psychosocial functional impairment ☐ Affection/function impairment (i.e. withdrawn, reclusive, labile)
☐ Psychomotor retardation or excitation ☐ Trauma ☐ Thought impairment ☐ Cognitive impairment
☐ Psycho-physiological condition (i.e. bulimia, anorexia nervosa)
☐ Substance Use*** (if selected, how is/will this be addressed describe):

☐ SED*** If present, describe in detail below:

Risk to Self? ☐ None ☐ Mild ☐ Moderate ☐ Severe
Risk to Others? ☐ None ☐ Mild ☐ Moderate ☐ Severe

Is child at risk for out-of-home placement? ☐ Yes ☐ No
If Yes:
At risk for what type of out-of-home placement? ☐ Psychiatric hospitalization ☐ RTF ☐ Foster Care
☐ Juvenile Court Placement ☐ Other (please specify) _____
Is child returning home from an out-of-home placement and FBMHS is needed as a step-down? ☐ Yes ☐ No
If yes, please describe:

Family Information:

CHILD AND FAMILY STRENGTHS (include individual strengths, family strengths, natural supports and community linkages):

Biological Mother: _____ Address: _____ Phone: _____

Biological Father: _____ Address: _____ Phone: _____

Legal Guardian(s) / Relationship: _____ Address: _____ Phone: _____

Other Mental Health Services in the household?

Family member that has agreed to engage and work with FBMHS team? _____

Others Living in Household

Last Name, First Name _____ Relationship to the Child**:** _____

Last Name, First Name _____ Relationship to the Child**:** _____

Describe detailed information regarding psychiatric symptoms / behavior problems / significant psychosocial stressors that may interfere with child / family function in the home:

Previous and Current Treatment: If selected enter dates and Provider

ICM/RC or Blended Case Management: _____ Outpatient: _____

Partial: _____ Family Based: _____

BHRS (wraparound): _____ Psychiatric Hospitalization: _____

Family Functional Therapy (FFT): _____ Multi-Systemic Therapy (MST): _____

Residential Treatment Facility or CRR: _____ CYS/JPO: _____

Intellectual Disabilities: _____ Substance Use Services: _____

Current Medications:

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Name: _____ Dose: _____ Frequency: _____

Medical Concerns*:*

Has the child had a physical examination in the past 12 months? ☐ Yes ☐ No Date of Exam: _____

Has the child had psychiatric/psychological evaluation in the past 6 months? ☐ Yes ☐ No ☐ Unknown if yes date? _____

Complete Precert Packet must include: ***(please check that the following is attached)***

☐ Best Practice Prescription Letter/Psychiatric or Psychological Eval.

*****INITIAL TREATMENT PLAN , CRISIS PLAN AND PSYCIATRIC/PSYCHOLOGICAL EVALUATION MUST BE SUBMITTED TO BEACON HEALTH OPTIONS WITHIN 8 WEEKS FROM THE START DATE OF FAMILY BASED SERVICES

Attach Completed Pre-Cert Authorization form in ProviderConnect

Referral Instructions:

Fax complete packet to the Family Based Mental Health Service provider chosen by the family.

- ✓ **Pre-cert form**
- ✓ **Best Practice Prescription Letter/Psychiatric or Psychological Eval.**