carelon Behavioral Health

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☐ Psychosocial functional impairment ☐ Affection/function impairment (i.e. withdrawn, reclusive, labile)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: