✓MetroPlusHealth

CHILD AND FAMILY TREATMENT SERVICES AND SUPPORTS (CFTSS) FORM

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E~ fxج‡á **CHILDRENSSPECIALSERVICE@METROPLUS.ORG**

Please use this Child and Family Treatment Services and Supports (CFTSS) request form for **concurrent requests** before the 24th service date. All information must be complete. If the services are deemed appropriate, then a minimum of 30 visits will be authorized. Submit the form for concurrent review 14 days before the authorization end date. 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.

Member Information:

Member name: _____ Member DOB: _____
Member ID: _____ Eligible for HCBS services ___Yes ___No
Guardian: _____ Enrolled in HCBS services (if known) ___Yes ___No
Contact number: _____
Member Address: _____
Health Home or OPWDD Care Coordination Organization (CCO): (if applicable) _____
Health Home or CCO Care Manager (if applicable): _____
MMCP Case Manager (if known):_____
MMCP Contact number/extension: _____ Email: _____
Primary Care Provider PCP) (if known): _____ PCP telephone: _____

Children and Family Treatment Support Services Requested

Please select each service for which authorization is being requested (more than one can be selected on one form):

☐ Community Psychiatric Supports & Treatment ☐ Psychosocial Rehabilitation

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: _____
OLP name: _____ OLP Agency: _____ OLP tel: _____

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

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- 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.

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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: _____