Children and Family Treatment and Support Services (CFTSS)
Documentation of Medical Necessity

Instructions: This form can only be completed and signed by a Licensed Practitioner of the Healing Arts (Individual currently licensed as a Registered Professional Nurse, Nurse Practitioner, Psychiatrist, Licensed Psychologist, Licensed Psychoanalyst, Licensed Master Social Worker, Licensed Clinical Social Worker, Licensed Marriage & Family Therapist, Licensed Mental Health Counselor, or Licensed Creative Arts Therapist, or Physician).

Recommendation for Rehabilitative Service(s):

Participant Name:		Date of Birth:	
Parent/Caregiver:		Relationship:	
Address:		Phone:	
State, City, Zip		Medicaid CIN:	

Behavioral Health Information: (*A MH/SUD diagnosis is only required for a recommendation of PSR):

	Diagnosis Category	Specific Diagnosis or Symptoms of Mental Illness (MH)/Substance Use (SUD)	Dx Code
Primary			
Secondary			
Other			

Areas of Functioning: (As a result of the symptoms or diagnosis of MH/SUD: the child/youth has functional impairment that interferes with or limits functioning in at least one of the following areas and is likely to benefit from and respond to the service(s) recommended to prevent the onset of symptoms or worsening of symptoms.) Check all that apply:

Check	Domain	Description of Impairment
	Self-Direction/Control	
	Self-Care	
	Family Life	
	Social Relationships	
	Symptom Management	

Recommended Child and Family Treatment and Support Service(s):

	Rehabilitative Service:	**Description of Needed Intervention:**
☐	Other Licensed Practitioner (OLP)	
☐	Community Psychiatric Supports and Treatment (Intensive counseling)	The child/youth is expected to achieve skill restoration in at least one of the following areas (circle all that apply): ☐ Yes ☐ No a. Participation in community activities and/or positive peer support networks b. Personal relationships c. Personal safety and/or self-regulation d. Independence/productivity e. Daily living skills f. Symptom management g. Coping strategies and effective functioning in the home, school, social or work environment The child/youth is likely to benefit from and respond to the service to prevent the onset or worsening of symptoms, and: ☐ Yes ☐ No o Likely to benefit o Likely to prevent onset of symptoms o Likely to prevent worsening of symptoms

☐	Psychosocial Rehabilitation (Skill development and building)	The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms, and: ☐ Yes ☐ No o Likely to benefit o Likely to prevent onset of symptoms o Likely to prevent worsening of symptoms The service is needed to meet rehabilitative goals by restoring, rehabilitating, and/or support the child/youth's functional level to facilitate integration of the child as a participant of the community and family, and ☐ Yes ☐ No o Restoring functional level o Rehabilitating functional level o Facilitating participation (circle all that apply) Community School Family
☐	Family Peer Support Services (Supporting parents & building skills for the benefit of the child)	The parent/family is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms, and: ☐ Yes ☐ No o Likely to benefit o Likely to prevent onset of symptoms o Likely to prevent worsening of symptoms The parent/ family is available, receptive to and demonstrates need for improvement in the following areas: ☐ Yes ☐ No o Strengthening the family unit o Building skills within the family for the benefit of the child o Promoting empowerment within the family o Strengthening overall supports in the child's environment
☐	Youth Peer Support and Training (Training and support in treatment planning and reinforcement of skills)	The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms, and: ☐ Yes ☐ No o Likely to benefit o Likely to prevent onset of symptoms o Likely to prevent worsening of symptoms The child/youth is available, receptive to and demonstrates need for improvement in the following areas: ☐ Yes ☐ No o Enhancing youth's abilities to effectively manage comprehensive health needs o Maintaining recovery o Strengthening resiliency, self-advocacy o Developing competency to utilize resources and supports in the community o Transition into adulthood or participate in treatment

Reason for Recommendation:

**By signing below,
I am recommending the above-named individual for Child and Family Treatment and Support Service(s)

Date of Medical Necessity Determination:

LPHA Signature

Printed Name

Scope of Practice

NPI#

MMIS#

Phone Number

Email