COMMUNITY CARE
Behavioral Health Organization

Family Based Mental Health Services Pre-certification Request
All Counties

COMMUNITY CARE (this section to be completed by the Family Based Care Manager at Community Care)

FB Episode: | FB Priority: | CCBH:

FACILITY INFORMATION (this section to be completed by Family-Based provider only)

Date Referral Received: | Family-Based Provider:

Contact Person: | Phone:

REFERRAL INFORMATION (this section to be completed by referral source)

Date Referral Sent: | Referral Source/Contact Person: | Phone:

IDENTIFYING INFORMATION

Child's Name: | Date of Birth: | Age: | Gender: ◯ Male ◯ Female

Address: | Race:

Phone: | MA Number:

County: | Insurance:

FAMILY INFORMATION

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

Biological Mother: | Address: | Phone:

Biological Father: | Address: | Phone:

Others Living in Household (please include name, age, and relationship to child)

1.
2.
3.

Immediate Relatives Not Living in Household (please include name, age, and relationship to child)

1.
2.
3.

PRESCRIPTION INFORMATION (Of note, prescription for FBMHS must be sent with this form):

Prescriber's Name: | Phone: | Date of Prescription:

REASON FOR REFERRAL

- ☐ Suicidal/homicidal ideation/self-injurious behavior
- ☐ Psychosocial functional impairment
- ☐ Thought impairment
- ☐ Psycho-physiological condition(i.e. bulimia, anorexia nervosa)
- ☐ Psychomotor retardation or excitation
- ☐ Cognitive impairment
- ☐ Affection/function impairment (i.e. withdrawn, reclusive, labile)
- ☐ Impulsivity and/or aggression
- ☐ Substance abuse

Please provide information on: severity and frequency of psychiatric symptoms, behavior problems, family issues and significant psychosocial stressors that are affecting child/family functioning; current services and discharge status; history of treatment engagement.

RISK

Is child at risk for out-of-home placement? ◯ Yes ◯ No If yes, explain why:

What type of out-of-home placement?

◯ Psychiatric Hospitalization ◯ RTF ◯ Foster Care ◯ Juvenile Court Placement ◯ Other (Please Specify)

Does the child pose a risk to the safety of self or others? ◯ Yes ◯ No If yes, explain why:

Is the child able to be managed safely outside of an inpatient setting or psychiatric residential treatment facility?

Is FBMHS needed as a step-down because the child is returning home from an out-of-home placement?

DIAGNOSTIC INFORMATION

Psychiatrist / Psychologist: Phone:

Current Mental Health Diagnosis:

Axis I

Axis I

Axis II

Axis III

Current Medications:

Axis IV

Axis V

PHYSICAL HEALTH INFORMATION

Primary Care Physician: Has child had a physical examination within the past 12 months? ◯ Yes ◯ No Date:

Does child have an Axis III diagnosis of **Obesity?** ◯ Yes ◯ No Height: ft in Weight: lb

Does the child have a physical health condition that interferes with activities of daily living? ◯ Yes ◯ No

Does the child's physical health condition influence their behavioral disorder? ◯ Yes ◯ No

Does the child have Commercial Primary? ◯ Yes ◯ No

Note the plans to address these physical health needs or the current treatment already in place:

EDUCATION

School: Grade: School Contact:

Educational Placement: Phone:

MENTAL HEALTH HISTORY

Previous and Current Treatment	Dates	Facility/Provider	Effectiveness (please comment)
☐ Case Management (please specify)	Start: End:		
☐ Outpatient	Start: End:		
☐ Partial	Start: End:		
☐ BHRSCA (wraparound)	Start: End:		
☐ Family-Based	Start: End:		
☐ Psychiatric hospitalization	Start: End:		
☐ Residential Treatment Facility	Start: End:		
☐ Other (please specify)	Start: End:		

OTHER RELEVANT HISTORY / INFORMATION / SERVICE INVOLVEMENT

☐ CYF Contact: Phone: Comments:

☐ JP Contact: Phone: Comments:

☐ D&A Contact: Phone: Comments:

☐ IDD Contact: Phone: Comments:

☐ Other Contact: Phone: Comments:

CHILD AND FAMILY STRENGTHS (include attributes, talents, relationship skills, natural and community supports)

Child:

Family:

OTHER PERTINENT INFORMATION

MISA screen was completed on: Does child use drugs or alcohol? ◯ Yes ◯ No Last Use:

Is there a substance abuse diagnosis? ◯ Yes ◯ No What is the plan for treatment?

Cigarette Smoking screen was completed on: Does child smoke cigarettes? ◯ Yes ◯ No

Has cessation been discussed? ◯ Yes ◯ No If female, is she pregnant? ◯ Yes ◯ No ◯ N/A

Domestic Violence screen was completed on:

Is the child a **witness** to domestic violence in the home? Currently: ◯ Yes ◯ No By History: ◯ Yes ◯ No

Is the child a **victim** to domestic violence in the home? Currently: ◯ Yes ◯ No By History: ◯ Yes ◯ No

Was a referral made for treatment? ◯ Yes ◯ No To Whom?

PERFORMANCE OUTCOME MANAGEMENT SYSTEM

Priority Population Grouping	Independence of Living Status	
◯ Child or Adolescent with EPSDT plan	◯ C&A Alone	◯ C&A in Supervised Setting
◯ Child or Adolescent at risk for EPSDT plan	◯ C&A in Family Setting	◯ C&A in Restrictive Setting
◯ Child or Adolescent in treatment (no EPSDT risk)	◯ C&A Living Dependently	◯ C&A Homeless

Vocational/Educational Status

◯ C&A Competitive Employment ◯ C&A Meaningful Activity ◯ C&A Training/Education

◯ C&A No Activity ◯ C&A Work Program

Child/Adolescent Data

School Attendance	School Performance	School Behavior	Source of School Information
◯ Regular Attendance	◯ Above Average	◯ No behavior problems	◯ Child
◯ Sporadic attendance	◯ Average	◯ Occasional behavior problems	◯ Parent/Guardian
◯ Enrolled but rarely attends	◯ Below Average	◯ Constant behavior problems	◯ School system
◯ Dropped out this quarter	◯ Failing		◯ Interagency meeting
◯ Dropped out in a prior quarter			◯ Other
◯ Unknown ◯ N/A	◯ Unknown ◯ N/A	◯ Unknown ◯ N/A	◯ Unknown ◯ N/A

Complete Precert Packet must include:(please check that the following are included)

☐ Precert Form ☐ Best Practice Prescription Letter ☐ Referral Tracking Form(if applicable)

START DATE for Family-Based Services:

Reset Form Print Form