Children and Family Treatment Supports Services
Continuing Authorization Request Form

Instructions

Please submit this form for concurrent review for Children and Family Treatment Supports Services Psychosocial Rehabilitation (PSR) and/or Community Psychiatric Support & Treatment (CPST) before the fourth visit.

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: _____

Enrolled in HCBS services (if known) Yes ☐ No ☐
Guardian: _____ Contact number: _____

Member Address: _____

Health Home: (if applicable) _____

Health Home Care Manager (if applicable): _____

Primary Care provider (if known): _____ Contact #: _____

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: _____

Requested **PSR :** _____

Start date (1st service visit): _____Frequency (# services per wk.):_____
Intensity (hrs. per service):_____
Duration (e.g. 3 mos.): _____ Off-site (If Yes, how many units) _____
Diagnosis_____

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.

Goal/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
- 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

_____
_____
_____

Requested **CPST**: _____

Start date (1st service visit):_____Frequency (# services per wk.): _____
Intensity (hrs. per service): _____Duration (e.g. 3 mos.): _____ Off-site (If Yes, how many units) _____
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.

Goal/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
- 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 goal.
- Family involvement, if any
- Identify why an alternate service would not meet the child's needs

_____
_____
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