Children and Family Treatment Supports Services
Continued Stay Authorization Request Form

Instructions

Prior to the fourth visit, submit this form for Children and Family Treatment Support Services (CFTSS) Psychosocial Rehabilitation (PSR) and/or Community Psychiatric Support & Treatment (CPST). If services are deemed clinically appropriate, a minimum of 30 visits will be authorized for those initiating treatment.

Before the 30 authorized visits are fully utilized, submit this form along with an updated Treatment Plan for concurrent review. A medical necessity assessment will be conducted. Additional services may be approved based on the criteria outlined in the CFTSS Provider Manual and recommendations of a Child/Adolescent Board – Certified Psychiatrist, if necessary, in alignment with the dates specified in the Treatment Plan.

Forms should be submitted at least 14 days prior to the current authorization end date. **Note**: Prior authorization is not required for CFTSS

Member Information

Member name Member DOB

Member ID #

Check if member transferring from another MMCP? ☐ If checked, as of what date?

Enrolled in HCBS services, if known Yes ☐ No ☐

Parent/Legal Guardian name Phone

Consent to contact parent/guardian directly Yes ☐ No ☐ (if yes, attach member consent)

Member Address

Foster care agency/contact, if applicable

Home Health/Home Care manager details, if applicable

Primary Care provider name, if known PCP phone

Diagnosis, if applicable

CFTSS Provider Information

Provider/Agency name Tax ID

Provider Mailing Address

Agency contact name Phone

Email Address Best time to contact

Alternate contact (i.e. supervisor) name

Alternate phone Alternate email

PSR and CPST instructions

Provide details for continued stay by providing evidence of the following:

- Child's involvement towards their service goals and how they continue to meet criteria for services
- Child's progress towards 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
- Why an alternate service would not meet the child's needs

PSR

First service date Effective date of treatment plan
End date of treatment plan

Modality	Frequency	Intensity	Duration	Off-site (Y/N)	Schedule variation explanation, or n/a
Individual				N	
Group				N	

Continued stay criteria explanation

CPST

First service date Effective date of treatment plan
End date of treatment plan

Modality	Frequency	Intensity	Duration	Off-site (Y/N)	Schedule variation explanation, or n/a
Individual				N	
Group				N	

Continued stay criteria explanation