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| --- | --- | --- | --- | --- | --- | --- |
| **Date of Request** | Click or tap here to enter text. | | | **Requestor Type** | | Choose an item. |
| **Requestor Name** | Click or tap here to enter text. | | | **Requestor Phone** | | Click or tap here to enter text. |
| **Requestor e-mail** | Click or tap here to enter text. | | | | | |
| **Service Type** | Choose an item. | | | | | |
| **Case Status** | Family Support Services  High or Very High Risk | | | Judicial  Next Court Date: Click or tap to enter a date. | | |
| Diversion  Low or Moderate risk | | | Non-judicial | | |
| **Safety Plan** | In-home | Out-of-home | | No Safety Plan (Family Support Services/Diversion) | | |
| **FSFN Case Name** | Click or tap here to enter text. | | |  |  | |
| **Client Name** | Click or tap here to enter text. | | | **Client Phone #** | Click or tap here to enter text. | |
| **Client DOB** | Click or tap here to enter text. | | | **Client SS#** | Click or tap here to enter text. | |
| **Placement Type** | Choose an item. | | | **Client Type** | Choose an item. | |
| **Client Address** | Click or tap here to enter text. | | | **Caregiver Name**  **(if applicable)** | Click or tap here to enter text. | |
| **Directions to home**  **(Required for In-home Services)** | Click or tap here to enter text. | | | | | |
| **Medicaid Insurance**   Yes  No | | |  | | | |
| **Insurance Provider Name** | Click or tap here to enter text. | | | **Abuse Report #** | Click or tap here to enter text. | |
| **Medicaid or Other Insurance Number** | Click or tap here to enter text. | | | **County of Jurisdiction** | Click or tap here to enter text. | |
| **Requested Service** | Click or tap here to enter text. | | | **County of Service** | Choose an item. | |

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| **Case Information** |

1. What specifically happened that lead to the case being opened (sequence of events around the presenting problem – Not the abuse allegations):

Click or tap here to enter text.

1. What is the current safety plan or out-of-home plan? (must be attached to this form)

Click or tap here to enter text.

1. What is the family’s perspective of the current concern?

Click or tap here to enter text.

1. Barriers to service engagement (scheduling, transportation, lack of external supports, lack of phone, etc.)

Click or tap here to enter text.

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| **Assessment/Evaluation Request** |

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| Type of assessment or evaluation being requested: Choose an item.  If Other, please specify: Click or tap here to enter text.  Supporting Documentation for this request:  Click or tap here to enter text.  Please provide an explanation for why the assessment or evaluation is needed. What is the purpose for requesting this assessment or evaluation and what type of information do you hope to gain?  Click or tap here to enter text. |

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| **Supporting/Background Documentation** is necessary for service providers and required with the referral packet when requesting an assessment/evaluation. To expedite this request, please include at a minimum any of the following records, if available, in the referral packet. |
| Investigative Summaries / History of abuse reports and findings |
| CPT Report |
| Police Reports |
| CBHA |
| Court Documents (Relevant Court Orders, Shelter Petition, Dependency Petition, Predisposition Study) |
| Case Plan and Reviews |
| Previous Treatment Reports/Summaries |
| Past Intakes/Assessments/Evaluations (Psychological, Psychiatric, Mental Health, Substance Abuse, Psychosexual, Domestic Violence, School/Educational) |
| Other: Click or tap here to enter text. |

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| CPI/FCC Signature |  | Date |  | CPI/FCC Supervisor Signature |  | Date |

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| **TO BE COMPLETED BY UM DEPARTMENT** |

Check previously referred services (services related to this case only)

|  |  |
| --- | --- |
| In-home clinical | In-home Paraprofessional |
| Substance Abuse Assessment / Counseling | Domestic Violence Assessment / Counseling |
| Mental Health Assessment / Counseling | Parenting Course |
| Psychiatric Evaluation | Psychological Evaluation |
| Individualized Therapy/Assessment for sexually reactive/aggressive children | Behavior Analyst Services |

**Approval Information**

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| Approved Service: | |  | | | | Date Request Received | |  |
| Request denied because | | |  | | | | | |
| Request passed through | | | Funding Source: |  | | | | |
| Request approved, see approval information: | | | Funding Source: |  | | | | |
| Provider approved: |  | | | | Provider’s Phone: | |  | |
| FSFN Provider ID |  | | | | Provider’s e-mail: | |  | |
| Provider’s address: |  | | | | | | | |
| **After allotted units and authorization dates expire, further services will not be paid unless a new authorization is given. Do not render services without authorization.** | | | | | | | | |

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| **Authorization Tracking#**  (Fiscal year - Authorization # - Site) | | | | | **# of units** | **Approved Service / Unit Type:** |
|  | - |  | - |  |  |  |
|  | - |  | - |  |  |  |
|  | - |  | - |  |  |  |
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| Authorization Effective Dates: |  | through |  | Person Approving |  |
| Manager Approving: |  | | | Approval Date: |  |

**To Requestor:**

Please refer to the ‘previously referred services’ area for service coordination needs.

Services are approved; however, it is the responsibility of the referral requestor to contact the provider and schedule services.

PSF will not pay for any unit of Service unless you have received prior authorization to deliver the Service from a designated PSF Utilization Management staff member.

You also agree to send PSF an invoice monthly, by the tenth (10th) day following the end of the month in which Services delivered.

Invoices for services that were received greater than sixty (60) days following the date of service will not be paid.