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| --- | --- | --- | --- |
| Date of Request: |  | Requestor Type: |  |
| Requestor Name: | **Click or tap here to**  | Requestor Phone: | **Click or tap here to**  |
| Requestor e-mail: | **Click or tap here to**  |
| Case Status: | **Choose an item.** |
| Safety Plan: | [ ]  Yes [ ]  No  |  |  |
| FSFN Case Name: | **Click or tap here to**  | Abuse Report #: | **Click or tap here to**  |
| Client Name: | **Click or tap here to**  | Client Type: | **Choose an item.** |
| Client DOB: | **Click or tap here to**  | Client SS#: | **Click or tap here to**  |
| Client Address: | **Click or tap here to**  | Client Phone#: | **Click or tap here to**  |
| Placement Type: | **Choose an item.** | Caregiver Name: | **Click or tap here to**  |
| Insurance Provider: | **Click or tap here to**  | Medicaid #: | **Click or tap here to**  |
| County of Jurisdiction: | **Choose an item.** | County of Service: | **Choose an item.** |
| Service Requested: | **Click or tap here to**  |
| Justification for Request (Case Plan/Clinical Rec./Staffing, etc.): | **Click or tap here to**  |

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| **Case Information** |

1. Provide information about the needs of the individual or family. What are the specified outcomes that the service is expected to address? **Click or tap here to enter text.**
2. Engagement considerations (**recent drug screen results & date**, scheduling, lack of phone, transportation, family supports, current no contact orders or visitation restrictions, next court date if judicial case, directions to the home if needed, etc.): **Click or tap here to enter text.**

**Include a copy of the current safety plan with the service request if applicable.**

\*\*\* Supporting/Background Documentation is **required** with the service request to send to the provider. Must include FFA, FFA-Ongoing, and FFA-Ongoing Progress Evaluation if available. Additional documents (e.g. prior FSFN Investigative Summaries and FFAs, CPT Report, Police/**Law Enforcement Reports** (for victim’s compensation funding), CBHA, Court Orders and Documents, previous treatment Reports/Summaries, and past Intakes/Assessments/Evaluations – mental health, substance abuse, psychiatric, psychological, psychosexual, domestic violence, school/educational, medical) that are relevant.

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

**Approval Information**

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| Approved Service: | Click or tap here to  | Date Request Received: |   |
| [ ]  Request denied because: | Click or tap here to  |
| [ ]  Request approved, see approval information: | Funding Source: | Click or tap here to  |
| Provider approved: | Click or tap here to  |
| Provider Phone: | Click or tap here to  | Provider E-mail: | Click or tap here to  |
| **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 Number**(Fiscal Year - Authorization # - Site) | **# of Units** | **Approved Service / Unit Type:** |
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| Authorization Effective Dates: | Click or t | through | Click or t | Person Approving: | Click or tap here to  |
| Manager Approving(if applicable): | Click or tap here to  | Manager Approval Date: |   |

**To Requestor:**

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

**To Provider:**

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