PROJECT BRAVO
BEHAVIORAL HEALTH REDESIGN FOR ACCESS, VALUE & OUTCOMES

CLEAR FORM

VIRGINIA'S MEDICAID PROGRAM DMAS

THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

FUNCTIONAL FAMILY THERAPY (H0036)
INITIAL Service Authorization Request Form

Please be mindful of notes throughout this form providing reference to where documentation obtained during the Comprehensive Needs Assessment (CNA), as well as the (FFT-related documents) are relevant and can be used for efficiency. The Behavior Change Session Plan (used in FFT Supervision/Consultation) may serve as the Individualized Service Plan for this service, and thus this form does not reference ISP Goals.

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name:		Organization Name:	
Member Last Name:		Group NPI #:	
Medicaid #:		Provider Tax ID #:	
Member Date of Birth:		Provider Phone:	
Gender:		Provider E-Mail:	
Member Plan ID #:		Provider Address:	
Member Street Address:		City, State, ZIP:	
City, State, ZIP:		Provider Fax:	
Member Phone #: Legal Guardian Name/Contact Information (If applicable):		**Clinical Contact** Name and Credentials*:	
		Phone #	
		* *The individual to whom the MCO can reach out to in order to gather additional necessary clinical information.*	

Request for Approval of Services

Retro Review Request? ☐ Yes ☐ No

If the member is currently receiving this service, start date of service:

Proposed/Requested Service Information:

From_____(date), To_____(date), for a total of_____units of service.

Identify all known treatment periods of Functional Family Therapy that have been provided by any providers including the requesting provider in the past 12 months:

Provider	Dates of Service/Intervention	Outcomes

Primary ICD-10 Diagnosis	
Secondary Diagnosis(es)	

Other medical/behavioral health concerns (including substance use issues, personality disorders, dementia, cognitive impairments) that could impact services? ☐ Yes ☐ No (If yes, explain below.)

SECTION I: ADMISSION CRITERIA

Individuals must meet ALL of the criteria #1-7; note that some criteria have multiple sub-criteria for consideration.

1. What is the youth's age?

If the youth is outside of the range of 11 to 18 years old, please provide information in regards to the need for and appropriateness of this service.

2. Specify the DSM diagnosis corresponding with the ICD-10 diagnosis(es) on the previous page. (To meet criteria, the primary diagnosis must be in the areas of disruptive behavior, mood, substance use, or traumatic stress).

Describe the individual's current symptoms (including frequency, intensity and duration) and areas of functional impairment. Corresponding CNA Elements: 1,6, 7, 12

3. Within the past 30 calendar days, the youth has demonstrated **at least one** of the following that puts the youth at risk of out-of-home placement:

A. **Persistent and deliberate attempts to intentionally inflict serious injury on another person.** *Describe the details from this individual's experience; note that citing dates (when feasible) of these attempts helps to verify the criteria.*	☐ Yes ☐ No
B. **Ongoing dangerous or destructive behavior.** *Describe any repeated occurrences of behaviors that are endangering to self or others, are difficult to control, cause distress, or negatively affect the youth's health.*	☐ Yes ☐ No
C. **Increasing and persistent symptoms associated with depression or anxiety in combination with externalizing behaviors that have contributed to decreased functioning in the community.** *Symptoms were detailed in Question 1. Please provide any additional details to characterize how symptoms have been increasing or persistent over the last 30 calendar days.*	☐ Yes ☐ No

D. **Ongoing substance use or dependency that interfere with the youth's interpersonal relationships and functioning in the community.** *Please provide details here: What substance(s), use patterns and specific impacts on functioning?*	☐ Yes ☐ No
E. **The youth is returning home from an out-of-home placement and FFT is needed as a step-down service.** *Please provide the name of the placement, details concerning the youth's behavior and why the youth was admitted, any behavioral health treatment the youth received, and the youth's response to this treatment.*	☐ Yes ☐ No

4. Describe how the youth's successful reintegration or maintenance in the community is dependent upon an integrated and coordinated treatment approach that involves intensive family/caregiver partnership and how the FFT model presents a unique fit for this youth's problem behaviors. *Why is FFT the best fit for this youth?*

5. Please provide information on the identity and relationship of any identified family member(s)/caregiver(s) available to participate in FFT services with the youth.

6. Describe the arrangements for supervision at home/community that will ensure a reasonable degree of safety for participation in this service. If the youth/natural supports/provider have established a safety plan, you may cite that plan and attach to this service authorization request.

Section V: RECOVERY & DISCHARGE PLANNING

Discharge plans are an important tool to emphasize hope and plans for recovery. Planning for discharge should begin at the first contact with the individual. Recovery planning should include discussion about how the individual and service providers will know that the member has achieved sufficient progress to move to a lower, less intensive level of care or into full recovery with a maintenance plan.

Within FFT, completion of the Behavior Change Session Plan, Individual Service Plan as well as general fidelity to the model within supervision and consultation may serve to demonstrate these questions are being considered and thus the provider may attach those forms rather than filling out this section.

What would progress/recovery look like for this individual?

What barriers to progress/recovery can the individual, their natural supports, and/or the service provider identify?

What types of outreach, additional formal services or natural supports, or resources will be necessary to reach progress/recovery?

At this time, what is the vision for the level of care this individual may need at discharge from this service?

What is the best estimate of the discharge date for this individual? _____

By my signature (below), I am attesting that 1) an LMHP, LMHP-R, LMHP-S or LMHP-RP has reviewed the individual's psychiatric history and completed the appropriate assessment or addendum; and 2) that this assessment indicates that the individual meets the medical necessity criteria for the identified service. The assessment or applicable addendum for this service was completed on the following date: _____

Signature (actual or electronic) of LMHP (Or R/S/RP): _____

Printed Name of LMHP (Or R/S/RP): _____

Credentials: _____

Date: _____

Notes