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 (FFT) (H0036)

CONTINUED STAY Service Authorization Request Form

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 Continued Services			
Initial FFT admission date: **Retro Review Request?** ☐ Yes ☐ No From_____(date), To_____(date), for a total of_____ units of service.			
Primary ICD-10 Diagnosis			
Secondary Diagnosis(es)			
Medication Update			
Name of Medication	Dose	Frequency	For any changes, note if: New, Ended or Changed in dose/frequency from last authorization

Member Full Name: Medicaid #:

SECTION I: CARE COORDINATION

Please list all medical/behavioral services or community interventions/supports the individual has participated in since the last Authorization, as well as any changes:

Name of Service/Support	Provider Contact Info	Frequency	*For any changes, note if:* New, Ended or Changed in frequency/intensity from last authorization

Describe care coordination activities with these other services/supports since the last authorization.

SECTION II: RATIONALE FOR CONTINUED STAY & TREATMENT PROGRESS SUMMARY

Please attach the most recent Behavior Change Session Plan and/or Individual Service Plan (ISP)

The youth must meet **one** of the following criteria. Please indicate which of these are true for this individual and provide additional details to rationalize additional FFT services at this time.

Within the past 30 calendar days:

The youth's symptoms/behaviors and functional impairment persist at a level of severity adequate to meet admission criteria.	☐ Yes ☐ No

The youth has manifested new symptoms or maladaptive behaviors that meet admission criteria and the ISP has been revised to incorporate new goals;	☐ Yes ☐ No
Progress toward identified plan of care goal(s) is evident and has been documented based upon the objectives defined for each goal, but not all of the treatment goal(s) have been achieved.	☐ Yes ☐ No

Section III: Recovery and Discharge Plan

Discharge plans are an important tool to emphasize hope and plans for recovery. Planning for discharge from services 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 individual has made sufficient progress to move to a lower, less intensive level of care or into full recovery with a maintenance plan. ***These responses should reflect any updated understanding of the recovery and discharge plan since the last review. Within FFT, completion of the Behavior Change Session 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(s): _____

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

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

Credentials: _____

Date: _____

Notes Section