Catholic Charities
Steuben/Livingston
Stronger Together

CFTSS Medical Necessity Recommendation

(Must Accompany CFTSS Referral Form)

Youth's Name: _____ Youth's Medicaid Number: _____

Mental Health Diagnosis: _____ ICD-10 (F Code): _____

Diagnosis Date: _____

Instructions: This form can only be completed and signed by a Licensed Practitioner of the Healing Arts (currently licensed as a Registered Professional Nurse, Nurse Practitioner, Psychiatrist, Licensed Psychologist, Licensed Psychoanalyst, Licensed Master Social Worker, Licensed Clinical Social Worker, Licensed Marriage & Family Therapist, Licensed Mental Health Counselor, Licensed Creative Arts Therapist, or Physician)

Recommended Children and Family Treatment and Support Service(s): *Check **all** that apply*:

☐ **Family Peer Support Services (FPSS)**: Services provided to families caring for a youth who is experiencing social, emotional, developmental, medical, substance use, and/or behavioral challenges in the home, school, placement, and/or community. FPSS services provide a structured, strength-based relationship between a trained Family Peer Advocate (FPA) with lived experience and the caregiver for the benefit of the youth, these services can be provided with or without the youth present.

Please describe the need for service: _____

_____

☐ **Psychosocial Rehabilitation (PSR):** Helps the child/youth learn skills to help support the child/youth in their home, school and community. The child/youth MUST have a Mental Health diagnosis to receive this service.

Please describe need for service:

_____

_____

☐ As a result of the symptoms or MH diagnosis, the child/youth has functional impairment that interferes with or limits functioning in at least one of the following areas AND is likely to benefit from and respond to the service(S) recommended to prevent the onset or worsening of symptoms.)

Check all that apply:

Check	Domain	Description of Impairment
	Self-Direction/Control	
	Self-Care	
	Family Life	
	Social Relationships	
	Symptom Management	

By signing below, I am recommending the above-named individual for Children and Family Treatment and Support Service(s)

_____ _____ _____ _____

LPHA Signature with credentials | Printed Name | **NPI # or Lic #** | Date

Please send documents by secure email to child.services@dor.org along with CFTSS Referral