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): _____
(If available)

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*:

☐ **Other Licensed Practitioner (OLP):** Provides individual, group, or family therapy in the home or in the community for a child/youth who has a Mental Health diagnosis whose treatment is better provided in home or community based settings OR is in need of a full assessment for a Mental Health Diagnosis.

Please describe need for service: **NOT YET AVAILABLE**
_____
_____

☐ **Community Psychiatric Supports and Treatment (CPST):** Maintains children/youth in their home and community, by helping to improve communication and interactions with family, friends and other through family support and training.

Please describe need for service: **NOT YET AVAILABLE**
_____
_____

☐ **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 Printed Name NPI # Date

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