CFTSS Medical Necessity Form

Instructions: This form may only be completed and signed by a Licensed Practitioner of the Healing Arts(LPHA) (individual currently licensed as a Registered Nurse(RN), Nurse Practitioner (NP), Psychiatrist ,Licensed Psychologist, Licensed Psychoanalyst, Licensed Master Social Worker)LMSW), Licensed Clinical Social Worker (LCSW), Licensed Marriage & Family Therapist (LMFT), Licensed Mental health Counselor (LMHC),Licensed Creative Arts Therapist, or Physician).

Recommendation for Rehabilitative Services:

Child's Name (Last, First, M)	Date of Birth
Gender	Diagnosis
Address	Phone
County	Phone (If Different than Child's)
Parent/Caregiver	CIN Number
Social Security Number	Insurance Company

Areas of Functioning:

As a result of the symptoms or diagnosis of mental Health (MH)/Substance Use Disorder (SUD), the child/youth has functional impairment(s) 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	

Recommended Child & family Treatment and Support Service (S) check all that Apply:

Check	Rehabilitative Services	Description of Needed Intervention (If Known/applicable)
□	Family Peer Support Services	
□	Youth Peer Support Services	

Reasons for Recommendation:

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_____

_____

Medical Necessity Client is approved for services ☐ Yes ☐NO	If not approved , explain:

Medical Necessity:

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

_____	_____	_____	_____
** LPHA signature	Print name	NPI #	Date

DBID#