Show Me Healthy Kids

MANAGED BY HOME STATE HEALTH

Initial Treatment Foster Care Authorization Form

COVER PAGE

Upon completion of this form **please fax to 1-833-966-0769** or upload this document to your request via the provider portal at Homestatehealth.com.

Facility Name	
Facility NPI #	
Contact Person Name	
Phone #	
Fax #	
Level of Care / CPT Code Requested	
Modifiers	
Admit Date	
Member Name/DOB/DCN	
Other Insurance	
(if yes, please include policy information)	
Guardian name and phone #	
TFC CM name and phone #	
Dx at Admission	
Medical Issues	

CONTINUED NEXT PAGE:

State Custody/Foster Care	**Yes** ☐ **No** ☐
CD-137 Attached	**Yes** ☐ **No** ☐ **N/A** ☐
Recommendation from CD-137 is Treatment Foster Care	**Yes** ☐ **No** ☐
CS-9 Attached	**Yes** ☐ **No** ☐
Most recent psychiatric evaluation completed by psychologist, or advanced practice psychiatric nurse if available.	**Yes** ☐ **No** ☐
Documentation of previous treatment history and outcome of treatment, if applicable.	**Yes** ☐ **No** ☐ **N/A** ☐
What is the discharge plan at admission:	
Comments (optional):	