Show Me Healthy Kids
MANAGED BY HOME STATE HEALTH

Treatment Foster Care Re-Authorization Form

Upon completion of this form **please fax to 1-833-966-0769**.

Facility Name	
Facility NPI #	
Contact Person Name	
Phone #	
Fax #	
Level of Care / CPT Code Requested	
Modifiers	
Request Date	
Member Name/ DOB/DCN	
Other Insurance *(any changes)*	
Guardian name and phone# *(any changes)*	
TFC CM name and phone *(any changes)*	
Has member obtained a DLA-20 in the past 30 days? If yes, please attach	**Yes** **No**

Updated DX

1.
2.
3.
4.
5.
6.

Current Symptoms/Behaviors/Functional Deficits/Needs that necessitate continued stay at current level of care. Please tell us why member can't be treated at a lower level of care:
If applicable — bio/foster family contact (can include phone calls/passes/FT sessions):
List or narrative of reports below (This can consist of therapy/psych notes with current updates/progress)
Behavioral Health Report:
Mental Health/Trauma Report:
Education Report:
Significant incidents from the last reporting period:
Is member on any special precautions?

Current Medications:

Name and dose of medication	Start date	Adjustments to Med	Reason for Medication	Any significant updates

Is member compliant with taking meds:	**Yes** **No**
If no, explain:	
Any comments regarding meds:	

OUTPATIENT APPOINTMENTS IN LAST REPORTING PERIOD

Provider	Service	Date
Comments/concerns:		

DATES OF SESSIONS THIS REPORTING PERIOD

Individual Therapy	Group Therapy	Family Therapy	Treatment Plan Meeting	Other

Treatment Plan Updates/Notes:
Discharge Plan/Follow Up:
Discharge disposition:

What movement has there been regarding discharge during this reporting period?
Barriers to discharge:
Tentative timeline for discharge: