VALUE BEHAVIORAL HEALTH of PENNSYLVANIA
A VALUEOPTIONS COMPANY

Family Based Mental Health Services Pre-Cert Form

IDENTIFYING INFORMATION			
Child's Name:	Date of Birth/Age:	Gender:	Race:
Address:	Phone:	Social Security Number:	
County:	Insurance:	MA Number:	

FACILITY INFORMATION *(This section to be completed by family based provider only)*

Date: _____ Family Based Provider: _____

Contact Person: _____ Phone: _____

REFERRAL INFORMATION

Referral Source: _____ **Contact Person:** _____ **Phone:** _____

Psychiatrist / Psychologist: _____ **Phone:** _____

DSM-5 DIAGNOSIS:	
Behavioral Diagnosis (ICD Code & Description):	
Medical Diagnosis:	
Social Elements Impacting Diagnosis:	
OPTIONAL FUNCTIONAL ASSESSMENT:	
Assessment:	Score:

Outpatient MH treatment is inappropriate or insufficient to meet the needs of the CHILD because:

REASON FOR REFERRAL

- ☐ Suicidal/homicidal ideation/self-injurious behavior
- ☐ Impulsivity and/or aggression
- ☐ Affection/function impairment (i.e. withdrawn, reclusive, labile)
- ☐ Psychomotor retardation or excitation
- ☐ Trauma
- ☐ Psycho-physiological condition (i.e. bulimia, anorexia nervosa)
- ☐ Psychosocial functional impairment
- ☐ Thought impairment
- ☐ Cognitive impairment
- ☐ Substance abuse
- ☐ SED*** If present, describe in detail below::

RISK

Is child at risk for out-of-home placement? ☐ YES ☐ NO Has the child ever been placed out of the home? ☐ YES ☐ NO If yes, explain:	At risk for what type of out-of-home placement? ☐ Psychiatric hospitalization ☐ RTF ☐ Foster Care ☐ Juvenile Court Placement ☐ Other (please specify)

FAMILY INFORMATION

Legal Guardian(s) / Relationship:	Biological Mother:	Biological Father:
Address:	Address:	Address:
Phone:	Phone:	Phone:

Other Mental Health Services in the household?	***Which family member are they working with?***

Others Living in Household ***Last Name, First Name***	**Relationship to the Child**

Member's Risk to Self:	**Member's Risk to Others:**
☐ 0 (None) ☐ 1 (Mild or Mildly Incapacitating) ☐ 2 Moderate or Moderately Incapacitating ☐ 3 (Severe or Severely Incapacitating ☐ NA (Not Assessed)	☐ 0 (None) ☐ 1 (Mild or Mildly Incapacitating) ☐ 2 Moderate or Moderately Incapacitating ☐ 3 (Severe or Severely Incapacitating ☐ NA (Not Assessed)

Describe detailed information regarding psychiatric symptoms / behavior problems / significant psychosocial stressors that may interfere with child / family function in the home:

Previous and Current Mental Health Treatment	**Dates**	**Facility/Provider**
☐ ICM/RC or Blended Case Management		
☐ Outpatient		
☐ Partial		
☐ BHRS (wraparound)		
☐ Family Based		
☐ Psychiatric Hospitalization		
☐ Residential Treatment Facility or CRR		

CURRENT MEDICATION		
Name	**Dose**	**Frequency**

Any medical concerns:	
Has the child had a physical examination in the past 12 months?	☐ YES ☐ NO
Has the child had psychiatric/psychological evaluation in the past 6 months?	☐ YES ☐ NO ☐ UNKNOWN *If YES, date of eval:*
Date of Best Practice Recommendation for family based mental health services: ***(**RECOMMENDATION FOR FB MUST BE ATTACHED**)***	Prescriber / Phone:

CHILD AND FAMILY STRENGTHS (include individual strengths, family strengths, natural supports and community linkages)
Is child returning home from an out-of-home placement and FBMHS is needed as a step-down? If yes, please describe. ☐ YES ☐ NO

Complete Precert Packet must include: ***(please check that the following are included)***

☐ Precert Form

☐ Best Practice Prescription Letter/Psychiatric or Psychological Eval.

Start Date for Family Based Services:

Provider Signature:

Date:

AUTHORIZATION INFORMATION
# of Units Requested for 8 Weeks: 225
Date: to:
Date of Next Review: *(8 weeks from start date)*

FAX COMPLETED FORM TO VBH-PA: 1-855-439-2442