Magellan HEALTHCARE

Service Request Application (SRA) for:

Treatment Foster Care (TFC) – Case Management Services Continued Stay Request

ALL ITEMS ARE REQUIRED

After response is entered, use the **Tab key** to advance to next item.

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name		Provider Name	
Member Last Name		Clinical Contact Name	
Medicaid Number		Provider MIS#	
Member Date of Birth		Provider Tax ID#	
		Provider NPI	
Gender	☐Male ☐Female	Provider Phone	
Member Phone Number		Provider Email	
Member Address City, State & Zip Code		Service Address City, State & Zip Code	

CLINICAL INFORMATION		
Procedure Code	T1016	
Primary Diagnosis		
Secondary Diagnosis		
Requested Units		
Requested Start Date		Is this a retro review request? ☐ Yes ☐ No
Requested End Date		
CSA Locality Code		

INTAKE
1. Have you submitted an SRA for this service and for this individual within the last 30 days which was not approved? ☐ Yes ☐ No a. If yes, please describe what changes have occurred to indicate that this service is now necessary?
2. Date of Comprehensive Treatment and Services Plan:
3. Have the locality and clinicians working with this child determined continued TFC-CM is required to meet the individual's needs? ☐ Yes ☐ No
4. Have two (2) face-to-face contacts between the TFC case manager and the child (one of which is in the foster home) occurred each month to ensure the child is receiving safe and effective services? ☐ Yes ☐ No

COORDINATION OF CARE
5. Does individual have a Primary Care Physician (PCP)? ☐ Yes ☐ No a. If yes, has there been communication with PCP to provide updates regarding treatment and to coordinate care? ☐ Yes ☐ No
6. Does this individual already receive any type of case management services, either as a standalone service or as part of any other service? ☐ Yes ☐ No a. If yes, type of case management services: b. If yes, name of case management service provider:
7. Have Health, Safety and Welfare issues been identified with this individual? ☐ Yes ☐ No a. If yes, has a Child Protective Services (CPS) referral been made? ☐ Yes ☐ No b. If, no, what intervention(s) have been taken to address this concern?
8. List any physical health conditions which require treatment:
9. List all medications (for physical and behavioral health conditions) that individual is taking:
10. Has individual expressed suidical ideation during last authorization period? ☐ Yes ☐ No a. If yes, what is the safety plan?

CLINICAL

11. Please describe current behaviors. Provide a narrative of the behaviors exhibited by the individual over the past 30 days that warrant Treatment Foster Care Case Management. (Please identify frequency, setting, intensity and duration of each behavior and avoid using vague language such as 'aggressive'). This information should reflect the Child and Adolescent Needs and Strengths (CANS) scoring and should come from the most current 90 day progress report:

12. Describe *mental health* treatment goals for the individual as it relates to the requested service:

13. Date of most recent Children and Adolescent Needs and Strengths (CANS):

14. **Please submit the completed CANS with this SRA** and complete the summary below. Please only provide scores for those domains that resulted in a '2' or a '3':

Child Behavioral/ Emotional Needs			**Child Risk Behaviors**		
2=Causing problems, diagnosable disorder. 3=Causing severe / dangerous problems.			2 = Recent, Act. 3 = Acute, Act Immediately.		
Domain	**2**	**3**	**Domain**	**2**	**3**
Psychosis:	☐	☐	Suicide Risk:	☐	☐
Impulse / Hyper:	☐	☐	Self-Mutilation:	☐	☐
Depression:	☐	☐	Other Self-Harm:	☐	☐
Anxiety:	☐	☐	Danger to Others:	☐	☐
Oppositional:	☐	☐	Sexual Aggression:	☐	☐
Conduct:	☐	☐	Runaway:	☐	☐
Adjustment to Trauma:	☐	☐	Delinquent Behavior:	☐	☐
Anger Control:	☐	☐	Fire Setting:	☐	☐
Substance Use:	☐	☐	Social Behavior:	☐	☐
Eating Disturbance:	☐	☐	Sexually Reactive Behavior:	☐	☐
			Bullying:	☐	☐

CLINICAL
15. What level of family support is available?
16. Describe the individual's functional level and clinical stability:
17. What is the current discharge plan? The discharge plan should include aftercare services or state what individual will have in place of these services. This plan should identify specific agencies and a plan to connect individual to these agencies: