Magellan HEALTHCARE®

Service Request Application (SRA) for:

Treatment Foster Care (TFC) – Case Management Services Initial 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#	
Gender	☐ Male ☐ Female	Provider NPI	
		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. Is the individual a transfer from another provider? ☐ Yes ☐ No
   a. If yes, please list previous provider if known:
2. 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:

Intake
3. Admission Date of Treatment Foster Care:
4. Date of Family Assessment Planning Team (FAPT) assessment: a. **Attach a copy of the FAPT Assessment with this SRA.**

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:

COORDINATION OF CARE

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. For the initial review, 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’):

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

CLINICAL
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:	☐	☐

15. Which level of impairment/risk does the individual's condition meet (see description below)?

☐ Level 1 - Moderate impairment with one or more of the following moderate risk factors as documented on the state-designated uniform assessment instrument (CANS):
- Needs intensive supervision to prevent harmful consequences;
- Moderate/ frequent disruptive or noncompliant behaviors in home setting that increase the risk to self or others;
- Needs assistance of trained professionals as caregivers.

☐ Level 2 - Individual must display a significant impairment with problems with authority, impulsivity and caregiver issues as documented on the CANS. For example, the individual must:
- Be unable to handle the emotional demands of family living;
- Need 24-hour immediate response to crisis behaviors; or
- Have severe disruptive peer and authority interactions that increase risk and impede growth.

☐ Level 3 - Individual must display a significant impairment with severe risk factors as documented on the CANS. Individual must demonstrate risk behaviors that create significant risk of harm to self or others.

☐ Non Treatment Foster Care

CLINICAL
16. Please describe alternative placements tried or explored and if they were successful or unsuccessful:
17. What level of family support is available?
18. Describe the individual's functional level and clinical stability:

CLINICAL	
19.	**Please submit the Initial Plan of Care with this SRA.**
20.	Which of the following will be submitted with this SRA? (one must be submitted) ☐ Written documentation that the Community Planning and Management Team (CPMT) has approved the admission to treatment foster care ☐ Certification by the FAPT that TFC case management is medically necessary
21.	What is the 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: