beacon
health options

Family Based Mental Health Services: Pre-Cert Form

Childs Name: MA ID #: DOB: Gender:

Date of Best Practice Recommendation for family based mental health services?
Prescriber NPI # ? **(Referral instructions below)**

Outpatient MH treatment or other community based services are inappropriate or insufficient to meet the needs of the CHILD because:

Reason for Referral:

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Psychosocial functional impairment Affection/function impairment (i.e. withdrawn, reclusive, labile)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

Risk to Self? (None, Mild, Moderate, Severe)
Risk to Others?(None, Mild, Moderate, Severe)

Is child at risk for out-of-home placement? Yes/No
If Yes:
At risk for what type of out-of-home placement? ☐ Psychiatric hospitalization ☐ RTF ☐ Foster Care
☐ Juvenile Court Placement ☐ Other (please specify)
Is child returning home from an out-of-home placement and FBMHS is needed as a step-down? Yes/No
If yes, please describe:

Family Information:

CHILD AND FAMILY STRENGTHS (include individual strengths, family strengths, natural supports and community linkages):

Biological Mother: Address: Phone:

Biological Father: Address: Phone:

Legal Guardian(s) / Relationship: Address: Phone:

Other Mental Health Services in the household?

Family member that has agreed to engage and work with FBMHS team?

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

Last Name, First Name Relationship to the Child:

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

Previous and Current Treatment: If selected enter dates and Provider

ICM/RC or Blended Case Management: Outpatient: Partial: Family Based:
BHRS (wraparound): Psychiatric Hospitalization: Family Functional Therapy (FFT):
Multi-Systemic Therapy (MST): Residential Treatment Facility or CRR; CYS/JPO:
Intellectual Disabilities : Substance Use Services:

Current Medications:

Name: Dose: Frequency:

Name: Dose: Frequency:

Name: Dose: Frequency:

Name: Dose: Frequency:

Medical Concerns*:*

Has the child had a physical examination in the past 12 months? Yes/No Date of Exam:

Has the child had psychiatric/psychological evaluation in the past 6 months? Yes/No/Unknown if yes date?

Complete Precert Packet must include: ***(please check that the following is attached)***

☐ Best Practice Prescription Letter/Psychiatric or Psychological Eval.

*******INITIAL TREATMENT PLAN , CRISIS PLAN AND PSYCIATRIC/PSYCHOLOGICAL EVALUATION MUST BE SUBMITTED TO BEACON HEALTH OPTIONS WITHIN 8 WEEKS FROM THE START DATE OF FAMILY BASED SERVICES**

Attach Completed Pre-Cert Authorization form in ProviderConnect

Referral Instructions:

Fax complete packet to the Family Based Mental Health Service provider chosen by the family.

- ✓ **Pre-cert form**
- ✓ **Best Practice Prescription Letter/Psychiatric or Psychological Eval.**