Family Centered Treatment
Prior Authorization Form for Initial Request

Requesting FCT Provider:		Contact Name and Number
City/Location:		Contact Fax Number:
Member ID:	Member DOB:	Member Last Name, First Name:

Behavioral Health Diagnosis (include most recent and any previous diagnoses):

Has the member received any Home- and Community-Based Services (HCBS) in the last 90 days? If the member is stepping down from Residential Treatment, please list that information here.

Provider:

Services:

Frequency:

Individual therapy sessions in the last 90 days?

Frequency:

Last Session:

Is the member/family noncompliant with any treatment services? If yes, explain:

Does the member receive medication management?

Frequency:

Last Session:

Has the member been compliant with medications? ☐ Yes ☐ No

Has the member received crisis intervention in the last 90 days? If so, state when and describe the outcome:

Does the member have a strong support system? Please explain:

Is the member in DCFS custody? If so, please list caseworker and contact number if available:

Does the member have legal charges? If so, state them:

List current symptoms/behaviors preventing the member from being managed safely through other HCBS and counseling services:

Please describe the specific symptoms and/or behaviors the member has exhibited consistently over the past six months. Include any resulting harm or injury to the member, others, or property, if applicable.

Has the member had any recent acute hospitalizations or emergency department visits for a behavioral health reason? If so, please list dates/reasons for any over the last 90 days:

If the member has not had OP in the last 90 days and needs family-centered treatment, please explain their barriers for OP treatment and why they are at risk for out-of-home placement:

Please attach the FCT assessment and Treatment Plan to this form.

Does the member have a strong support system? Please explain:

Name of Licensed Mental Health Professional:	Signature:	Date: