WESTMORELAND COUNTY BEHAVIORAL HEALTH & DEVELOPMENTAL SERVICES-CHILDREN'S SERVICES

Family Based Mental Health Services County Funding Request

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:** _____

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

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

Others Living in Household *(Please include name, age, and relationship to child)*	**Immediate Relatives NOT Living in Household** *(Please include name, age, and relationship to child)*

EDUCATION	
School:	Grade:
Educational Placement:	School Contact & Phone: /

MEDICAL / PSYCHIATRIC HISTORY	
Physical Health Plan:	
Primary Care Physician:	Phone:
Current Mental Health Diagnosis:	**Current Medications:**
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 If YES, date of eval:
Date of prescription for family based mental health services: ***(**PRESCRIPTION FOR FB MUST BE ATTACHED**)***	Prescriber / Phone: /

Previous and Current Mental Health Treatment	**Dates**	**Facility/Provider**
☐ Case Management (please specify)		
☐ Outpatient		
☐ Partial		
☐ IBHS (formally BHRS)		
☐ Family Based		
☐ Psychiatric Hospitalization		
☐ Residential Treatment Facility		
☐ Other (please specify)		

BSU: Westmoreland Case Management & Supports	BSU Case Manager:

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ideation/self-injurious behavior ☐ Impulsivity and/or aggression ☐ Affection/function impairment (i.e. withdrawn, reclusive, labile) ☐ Psychomotor retardation or excitation ☐ Trauma	☐ Psycho-physiological condition (i.e. bulimia, anorexia nervosa) ☐ Psychosocial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

****Please include detailed information regarding psychiatric symptoms / behavior problems / significant psychosocial stressors that may interfere with child / family function:**

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

OTHER RELEVANT HISTORY / INFORMATION / SERVICE INVOLVEMENT
☐ CYS Contact / Phone: /
☐ JP Contact / Phone: /
☐ D & A Contact / Phone: /
☐ ID/D Contact / Phone: /
☐ Other Contact / Phone: /

COUNTY/BASE FUNDING REQUEST

___Family has applied for Medical Assistance and is awaiting decision. Date of application:_____

___Family has NOT applied for Medical Assistance

___Family is NOT willing or refusing to apply for Medical Assistance

Reason for refusal: _____

___Child does not have insurance

___Child has private insurance that does not provide behavioral health coverage/benefits

___Child is eligible for Medical Assistance benefits but is not eligible for HealthChoices

___Child/Family has HIPP insurance

Other (please explain):

RISK

Is child at risk for out-of-home placement? ☐ YES ☐ NO Has parent agreed to service and signed a release of information? ☐ YES ☐ NO	At risk for what type of out-of-home placement? ☐ Psychiatric hospitalization ☐ RTF ☐ Foster Care ☐ Juvenile Court Placement ☐ Other (please specify)

Do the child's behaviors indicate manageable risk for safety to self or others? Is the child able to be managed outside of an inpatient setting or psychiatric residential treatment facility? **Please describe.**

☐ YES ☐ NO

Does the family recognize the child's risk of out-of-home placement and the problems of maintaining their child at home without intensive therapeutic interventions in the context of the family?

☐ YES ☐ NO

Is child returning home from an out-of-home placement and FBMHS is needed as a step-down? If yes, please describe.

☐ YES ☐ NO

Treatment is determined by the treatment team to be necessary in the context of the family to effectively treat the child?

☐ YES ☐ NO

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

☐ Precert Form

☐ Best Practice Prescription Letter/or evaluation

START DATE for Family Based Services:

_____ _____

Provider Signature **Date**

Please fax pre-certification form, recommendation letter and evaluation to Christina Weimer at 724-830-3571 (fax) or by email to weimerc@westmoreland.swsix.com