VALUE BEHAVIORAL HEALTH of PENNSYLVANIA
A VALUEOPTIONS COMPANY

FOR GUIDE ONLY

Family Focused/Solution Based Services 16-Week Review

IDENTIFYING INFORMATION		
Date:	Member Name:	MA #:
		SSN:
Date of Birth/Age:	Provider:	

Requested Start Date for Authorization:		Admit Date:	

CURRENT DIAGNOSIS	
Axis I:	
Axis II:	
Axis III:	
Axis IV:	
Axis V: (GAF Current)	
Any revision to diagnosis?	☐ YES ☐ NO

Member's Risk to Self:	Member's Risk to Others:
☐ 0 (None) ☐ 1 (Mild or Mildly Incapacitating) ☐ 2 Moderate or Moderately Incapacitating ☐ 3 (Severe or Severely Incapacitating ☐ NA (Not Assessed)	☐ 0 (None) ☐ 1 (Mild or Mildly Incapacitating) ☐ 2 Moderate or Moderately Incapacitating ☐ 3 (Severe or Severely Incapacitating ☐ NA (Not Assessed)
Has a crisis/safety plan been updated in collaboration with the family?	☐ YES ☐ NO

Number of crisis calls in the past 10 weeks:

Please describe:

Current Impairments

Key:

☒ 0 (None)	☒ 1 (Mild or Mildly Incapacitating)	☒ 2 Moderate or Moderately Incapacitating	☒ 3 (Severe or Severely Incapacitating	☒ NA (Not Assessed)

Mood Disturbances (Depression or Mania)	Weight Loss Associated with an Eating Disorder	Anxiety
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

Medical/Physical Conditions	Psychosis/Hallucinations/Delusions	Substance Abuse/Dependence
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

Thinking/Cognition/Memory/Concentration Problems	Job/School Performance Problems	Impulsive/Reckless/Aggressive Behavior
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

Social Functioning Relationships/Marital/Family Problems	Activities of Daily Living Problems	Legal
☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

LIST ONGOING GOALS / OBJECTIVES IN MEASUREABLE TERMS:
IDENTIFIED GOALS AND / OR OBJECTIVES ALREADY ACHIEVED:

CURRENT RATES OF BEHAVIOR (list each separately):

WHAT CHANGES HAVE BEEN MADE TO YOUR TREATMENT PLAN THAT WILL INCREASE THIS RATE OF COMPLIANCE:

NEW RESOURCES OR COMMUNITY SUPPORTS IDENTIFIED DURING THE FIRST 16 WEEKS (please list):

EDUCATIONAL STATUS	
Last contact with school:	
Any changes reported at school? *(Please list)*	

PROBLEMATIC BEHAVIOR CONTINUING TO PUT THE CHILD / ADOLESCENT AT RISK FOR OUT-OF-HOME TREATMENT:

CURRENT FAMILY CONCERNS / EXPECTATIONS FOR ONGOING TREATMENT:

Has child been Inpatient at any time in this past auth period? ☐ YES ☐ NO

MEDICATIONS		
NAME	DOSE	FREQUENCY

Prescribing psychiatrist:	
Any revision to medication in past 10 weeks? *(Please list)*	
Date of last medication monitoring appointment and with whom?	Date: With:
Has the member / family been compliant with medications as prescribed:	☐ YES ☐ NO
If no, why?	

REASON FOR CONTINUED STAY:

IDENTIFIED TREATMENT BARRIERS CONTINUING TO PREVENT PROGRESS IN TREATMENT:

BASELINE BEHAVIOR AT BEGINNING OF TREATMENT (list each identified behavior separately):

EXPECTED DISCHARGE DATE:		PLANNED DISCHARGE Level of Care:		PLANNED DISCHARGE RESIDENCE:	

Is Discharge Planned by week 24? ____________________
Date of Proposed ISPT meeting? ____________________
County Notified Via Fax to set up ISPT: ________________