

## Family Focused/Solution Based Services 6-Week Review

<b>FACILITY INFORMATION</b> <i>(This section to be completed by FFSBS provider only)</i>	
Date: _____	FFSBS Provider: _____
Contact Person: _____	Phone: _____

<b>IDENTIFYING INFORMATION</b>		
Child's Name: _____	Date of Birth: _____	MA Number: _____
		SSN: _____

Requested Start Date for Authorization: _____		Admit Date: _____	
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<b>DIAGNOSIS</b>	
Axis I	_____
Axis II	_____
Axis III (Medical)	_____
Axis IV (Stressors)	_____
GAS/GAF	_____

<b>Other Relevant Information</b>	
Has the child received a comprehensive psychiatric or psychological evaluation within 30 days of start date of service? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of the Evaluation: _____ If no, why? _____	
Is family vested in treatment/active family involvement (i.e., weekly face-to-face contact)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, why? _____	

<b>IDENTIFIED PROBLEMATIC BEHAVIORS THAT PUT THE CHILD / ADOLESCENT AT RISK FOR OUT-OF-HOME TREATMENT:</b>

**CHILD / ADOLESCENT FAMILY SUPPORT SYSTEM (please check):**

- Father     Mother     Maternal Grandparent(s)     Paternal Grandparent(s)     Younger Sibling(s)     Older Sibling(s)  
 Other (explain)

**Member's Risk to Self:**

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

**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)

**CRISIS PLAN**

Crisis Plan on File     Yes     No

Number of crisis calls past six weeks: \_\_\_\_\_

**Current Impairments**

**Key:**

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

<b>Mood Disturbances (Depression or Mania)</b>	<b>Weight Loss Associated with an Eating Disorder</b>	<b>Anxiety</b>
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A

<b>Medical/Physical Conditions</b>	<b>Psychosis/Hallucinations/Delusions</b>	<b>Substance Abuse/Dependence</b>
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A

<b>Thinking/Cognition/Memory/Concentration Problems</b>	<b>Job/School Performance Problems</b>	<b>Impulsive/Reckless/Aggressive Behavior</b>
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A

<b>Social Functioning Relationships/Marital/Family Problems</b>	<b>Activities of Daily Living Problems</b>	<b>Legal</b>
<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> N/A

**EDUCATION**

Grade Level	
Type of Classes	
Problems in school	
Current Grades	
IEP	<input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, goals of the IEP:</i>

Is a comprehensive treatment plan completed?  Yes  No If no, why?

LIST GOALS OF TREATMENT IN MEASUREABLE TERMS:


WHAT ARE THE MEMBER'S CURRENT RATE OF BEHAVIORS?


WHAT IS NEEDED IN YOUR TREATMENT PLAN TO INCREASE THIS RATE OF COMPLIANCE?  
WHAT SERVICES ARE NEEDED FOR THE MEMBER / FAMILY TO BE DISCHARGED?


CURRENT FAMILY CONCERNS (WHAT THE FAMILY SEES AS MOST SEVERE):


HAS MEMBER REQUIRED INPATIENT SINCE LAST REVIEW?

YES  NO Date: \_\_\_\_\_

CURRENT MEDICATION		
Name	Dose	Frequency

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Has the member / family been compliant with giving the medications as directed? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>If no, why?</i>

<b>IDENTIFIED TREATMENT BARRIERS:</b>

<b>PRIMARY REASON FOR CONTINUED STAY:</b>

<b>BASELINE BEHAVIORS</b>

Expected Discharge Date	
Planned Discharge Level of Care	
Planned Discharge Residence	

<b>XVI. COMPLETE 6-WEEK REVIEW PACKET MUST INCLUDE:</b>
<input type="checkbox"/> Crisis Plan
<input type="checkbox"/> Comprehensive Treatment Plan
<input type="checkbox"/> Comprehensive Psychiatric or Psychological Evaluation (if not sent with precertification)

**FAX TO: 724-744-6522**