PerformCARE

Child/Adolescent Services
BHRS Provider Report to Evaluator Form

- This form should be completed by the provider and submitted to the evaluator prior to the re-authorization evaluation along with a copy of the current treatment plan, indicating progress of the past period, upcoming goals and treatment intervention techniques for the next authorization period. This form should be included with the request submitted to PerformCare.

Member County of Residence:
☐Cumberland ☐Dauphin ☐Franklin ☐Fulton ☐Lancaster ☐Lebanon ☐Perry

Member's Name:_____ MAID #:_____

Name of Agency:_____ Agency Site:_____

Phone:_____ Contact Person:_____

Please check the level of family/legal guardian involvement in services during the current authorization period.
☐Very involved-*Participates in all sessions* ☐Moderate involvement-*Participates in more than half sessions*
☐Somewhat involved-*Participates in less than half* ☐No involvement-*Participates in no sessions*

If the authorization has lapsed prior to your reauthorization request submission, please explain why: ☐N/A

_____

_____

_____

Has your agency continued to provide services? ☐Yes ☐No, last date of service was _____

Date of Re-Evaluation: _____ Current Authorization Period: From: _____ To:_____

Current Services Authorized:
- ☐Behavioral Specialist Consultant: _____hours per week or month
- ☐Mobile Therapy: _____hours per week or month
- ☐Therapeutic Support Staff in School: _____hours per week or month
- ☐Therapeutic Support Staff in Home/Comm: _____hours per week or month
- ☐FBMHS
- ☐CRR-HH
- ☐BHRS exception services: _____

Services utilized in the current authorization period up to the date of the evaluation:
- ☐Behavioral Specialist Consultant: _____hours per week or month
- ☐Mobile Therapy: _____hours per week or month
- ☐Therapeutic Support Staff in School: _____hours per week or month
- ☐Therapeutic Support Staff in Home/Comm: _____hours per week or month
- ☐FBMHS

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☐CRR-HH
☐BHRS exception services:_____

If all authorized services and hours were not provided, please explain the reasons that services were not delivered and include the providers plan to deliver all services as authorized.

_____

_____

_____

Please communicate any recommended change(s) to services/hours and reason for changes to the evaluator here.

_____

_____

_____

Provider signature: _____ Date: _____

Print Name: _____

**Please note that the evaluator's signature reflects review of the information indicated on this form up to the date of the evaluation.

Evaluator signature: _____ Date: _____

Print Name: _____

A copy of the current treatment plan, indicating progress of the past period, upcoming goals and treatment intervention techniques for the next authorization period was provided to me for the evaluation. ☐Yes ☐no