PerformCARE®

Child/Adolescent Services

Family-Based Mental Health Services Recommendation Letter

Demographics

Member's Name: _____ MAID#: _____ DOB: _____

Address: _____

Phone #: _____

Member County:

☐ Cumberland ☐ Dauphin ☐ Franklin ☐ Fulton ☐ Lancaster ☐ Lebanon ☐ Perry

REL/SOGI (Complete each section and indicate if Member preferred not to answer).

Member's Race:_____ Member's Ethnicity:_____

Member's Sexual Orientation: _____ Member's Gender Identity:_____

Member's Assigned Sex at Birth:_____ Member's Pronouns: _____

Member's Alternative Name (if applicable): _____

Member's Primary Language:

Written: _____ Spoken: _____

Clinical Recommendation

Current Behavioral Health Diagnoses: _____

Determination of eligibility (all criteria must be met)

☐ One adult member agrees to participate in FBMH Services treatment.

☐ The child is at risk for out of home placement; or,

- ☐ If initial request returning form residential placement; or
- ☐ If initial request stepping down from inpatient stay.

☐ The child has a mental illness or emotional disturbance. Please indicate if known_____.

☐ The child serving systems involved with this child are in agreement with a request for FBMH services.

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Recommendation:

☐ I recommend Family Based Mental Health Services for the above-mentioned child and his/her family.

Signature of Prescriber: _____ Date: _____

Printed Name of Prescriber: _____

Address line 1: _____ State: _____

Address line 2: _____ Zip: _____

City: _____ Prescriber's phone number: _____

Please indicate professional title (Must be one of these professional types):

☐ Licensed Physician ☐ Licensed Psychologist ☐ CRNP ☐ Physician Assistant ☐ LPC ☐ LCSW ☐ LMFT

MA Provider ID: _____ Provider NPI#: _____
(Please enter the 9-digit MA Provider #)

All aspects of this form need completed, or the request will not be accepted as a complete request for medical necessity review by PerformCare.