

**SPECIALIZED THERAPEUTIC FOSTER CARE
INITIAL REVIEW**

Client Demographic Information:

Enrollee Name: _____
Enrollee Medicaid #: _____
Date of Birth: _____
Current Provider and
Level of Care: _____
Address.Phone #: _____

1. Call Demographics:

Date called to Magellan: _____
Name of Coordinator: _____
Response/review appt
date and time: _____
Follow up issues: _____

2. Provider of Service:

Provider Name: _____
Address/Zip: _____
Contact Person: _____
Phone #/Email: _____
Fax #: _____
Requested Begin Date: _____

3. Level of STFC requested:

Level I Level II Crisis Intervention

4. Reason for requested service (referral source, why now)?

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5. Clinical Diagnosis (all five axes):

	CODE	DESCRIPTION
I.		
II.		
III.		
IV.	Current Psychosocial Stressor(s):	
V.	GAF (Current):	GAF (Past Year):

6. Risk Assessment (e.g. suicidal, homicidal, plan):

7. Medical/Medications (physical and behavioral): [include dosage & frequency]

8. Psychosocial Summary (abuse/neglect, cultural, legal, substance abuse):

9. School (grade, special ed, absenteeism, suspension/expulsion):

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10. Previous treatment:

Type of Service/Support:	
Date:	
Outcome:	
Type of Service/Support:	
Date:	
Outcome:	
Type of Service/Support:	
Date:	
Outcome:	
Type of Service/Support:	
Date:	
Outcome:	

11. Current providers and supports:

Type of Service/Support:	
Date Began:	
Type of Service/Support:	
Date Began:	
Type of Service/Support:	
Date Began:	
Type of Service/Support:	
Date Began:	

12. Strengths:

13. Goals (behavior-based):

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14. Barriers:

15. Discharge plan:

16. Anticipated length of stay:

**SPECIALIZED THERAPEUTIC FOSTER CARE
CONCURRENT REVIEW**

Client Demographic Information:

Enrollee Name: _____
Enrollee Medicaid #: _____
Date of Birth: _____
Current Provider and
Level of Care: _____
Address/Phone #: _____

1. Call Demographics:

Date called to Magellan: _____
Name of Coordinator: _____
Response/review appt
date and time: _____
Follow up issues: _____

2. Requested Level/Service:

Provider Name: _____
Address/Zip: _____
Contact Person: _____
Phone #/Email: _____
Fax #: _____
Requested Begin Date: _____

3. Level of STFC requested:

Level I Level II Crisis Intervention

4. Rationale for continued stay:

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CONCURRENT REVIEW**

5. Clinical Diagnosis (all five axes):

	CODE	DESCRIPTION
I.		
II.		
III.		
IV.	Current Psychosocial Stressor(s):	
V.	GAF (Current):	GAF (Past Year):

6. Risk Assessment (e.g. suicidal, homicidal, plan):

7. Changes in medical/medications (physical and behavioral): [include dosage & frequency]

8. Changes in psychosocial situation (abuse/neglect, cultural, legal, substance abuse):

9. Changes in school (grade, special ed, absenteeism, suspension/expulsion):

**SPECIALIZED THERAPEUTIC FOSTER CARE
CONCURRENT REVIEW**

10. Changes in current providers and supports (type of service/support, date began):

11. Strengths:

12. Goals (behavior-based):

13. Barriers:

14. Discharge plan:

15. Anticipated discharge date:
