MENTAL HEALTH ASSOCIATION
FIND WELLNESS.

Medical Necessity Form - LPHA Recommendation for Children & Family Treatment & Support Services

Instructions*: This form can only be completed and signed by a Licensed Practitioner of the Healing Arts (Individual currently licensed as a Registered Professional Nurse, Nurse Practitioner, Psychiatrist, Licensed Psychologist, Licensed Psychoanalyst, Licensed Master Social Worker, Licensed Clinical Social Worker, Licensed Marriage & Family Therapist, Licensed Mental Health Counselor, or Licensed Creative Arts Therapist, or Physician)*

Recommendation for Rehabilitative Service(s)

DATE:

Participant Name:	Date of Birth:
Parent/Caregiver:	Relationship:
Address:	Phone:
County of Residence:	Medicaid CIN #:

Behavioral Health Information: (*A MH/SUD diagnosis is only required for a recommendation of PSR) *Check all that apply:*

List	Diagnosis Category	Specific Diagnosis or Symptoms of Mental Illness DXCode (MH)/Substance Use (SUD)	Code
Primary			
Secondary			
Other			

Areas of Functioning: (As a result of the symptoms or diagnosis of MH/SUD, the child/youth has functional impairment that interferes with or limits functioning in at least one of the following areas and is likely to benefit from and respond to the service(s) recommended to prevent the onset or worsening of symptoms.) *Check all that apply:*

Check	Domain	Description of Impairment
	Self-Direction/Control	
	Self-Care	
	Family Life	
	Social Relationships	
	Symptom Management	

Recommended Child and Family Treatment and Support Service(s): *Check all that apply:*

Check	Rehabilitative Service	Description of needed intervention
	Family Peer Support Services	☐ Engagement, Bridging, and Transition Support ☐ Self-Advocacy, Self-Efficacy and Empowerment ☐ Parent Skill Development ☐ Community Connections and Natural Supports ☐ Education Advocacy
	Youth Peer Support Services	☐ Self-Advocacy, Self-Efficacy and Empowerment ☐ Community Connections and Natural Supports ☐ Coaching ☐ Engagement, Bridging, and Transition Support ☐ Skill Building.

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Detailed Reason for Recommendation:

By Signing below I am recommending the above named individual for Child and Family Treatment Support Services:

_____	_____	_____	_____
LPHA Signature	**Printed Name**	**NPI #**	**Date**

MHA Family Support Services

274 North Goodman St., Suite D103

Rochester, NY 14607

Office: 585-325-3145 x 152

Email: mhafssreferral@mharochester.org

_____

MHA Office Use Only:

Date Received by: _____

Date Logged In by: _____

Date Approved by: _____

Date Referred Out:

Client ID: _____