

Effective Date: _____

To Whom It May Concern:

In my clinical assessment _____ (name of youth) meets Medical Necessity for Children and Family Treatment and Support Services (CFTSS) per information below:

Determination of Medical Necessity – Required for all services

Yes or No (Check one). In my clinical assessment, this youth needs/would benefit from these services to (check all that apply- at least one): Likely to prevent onset of symptoms Likely to prevent worsening of symptoms

The service is needed to meet rehabilitative goals by restoring functioning level to facilitate integration of the youth as a participant of the community and family; and (check all that apply- at least one):

Restore functioning level Rehabilitating functional level Facilitating participation in community, school, work, or home.

List DSM-5 or ICD-10 diagnoses:

Diagnosis Code:	Diagnosis(es):

and/or

Behavioral/Mental Health/Substance Abuse Symptoms:

*******REQUIRED- Services needed:**

In-Home Counseling (OLP) Evaluation (OLP) Intensive Services & Treatment (CPST) Skill Building (PSR)

Clinician Signature (with credentials): _____ Date: _____

Clinician Name (with credentials, printed): _____ NPI Number: _____

License Number: _____

Agency / Clinic Name (if applicable, printed): _____ Agency NPI: _____

Signature of Licensed Supervisor for MHC-Permit Holder (if applicable): _____

License Number: _____ NPI Number: _____

You can submit this form to Carolyn Little, Manager of Youth Service, via fax (607-937-3206), secure email (clittle@pathwaysforyou.org), or mail/in person (Administrative offices: 33 Denison Parkway W, Corning, NY 14830)