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 the Manager of Youth Services via fax (607-937-3206)
or by mail/in person (Administrative offices: 33 Denison Parkway W, Corning, NY 14830)