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.

Required for Family Peer Support Services (FPSS): The youth's family is available, receptive to and demonstrates need for improvement in the following areas such as (check all that apply- at least one): ☐Strengthening the family unit ☐ Building skills within the family for the benefit of the child ☐ Promoting empowerment within the family ☐Strengthening the family overall supports

Required for Youth Peer Support and Training (YPST): ☐ Yes or ☐ No (Check one): The youth requires involvement of a YPA to implement the intervention(s) outlined in the treatment plan; AND the youth is involved in the admission process and goal creation AND the youth demonstrates a need for improvement in the following areas (check all that apply- at least one): ☐Managing health needs ☐Maintaining recovery ☐Strengthening resiliency/self-advocacy ☐Self-efficacy and empowerment ☐ Utilizing community resources ☐Transitioning into adulthood

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)

☐ Family Peer Support Services ☐Youth Peer Support and Training (Available 1/1/20 for non-HCBS youth)

Clinician Signature (with credentials):_____ Date:_____

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

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

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)