new directions
YOUTH AND FAMILY SERVICES
fostering good.

***Children Family Treatment and Support Services***
***LPHA Recommendation For Rehabilitative Services***

**Instructions**: Select at least one item from each section (section 4 only required for FPSS recommendations). 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).

| **Youth Name:** | **Youth DOB:** |
|---|---|

**Section I: Behavioral Health Information** *Please select all that apply for the youth with a* ***minimum of one selection****)*

☐ 1. The child/youth has a behavioral health diagnosis that demonstrates symptoms consistent or corresponding with the DSM. (*Required for PSR. OLP or CPST may meet this requirement or option 2. FPSS may meet this requirement or option 3)*

| Priority | Diagnosis | Code |
|---|---|---|
| *Primary* | | |
| *Secondary* | | |
| *Other* | | |

☐ 2. The child/youth is at risk of development of a behavioral health diagnosis. *(alternative eligibility for OLP, CPST).*
*Describe:*

☐ The child/youth displays demonstrated evidence of skill(s) lost or undeveloped as a result of the impact of their physical health diagnosis. (*alternative eligibility for FPSS). Describe:*

**Section II: Responsiveness to services**

☐ The child/youth is likely to benefit from and respond to the service to prevent the onset or the worsening of symptoms

**Section III: Areas of Functioning:** *As a result of the symptoms or diagnosis of mental health, the child/youth has a functional impairment that interferes with or limits functioning in at least one of the following areas*

☐ Self-Direction/ Control ☐ Self-Care ☐ Family Life ☐ Social Relationships ☐ Symptom Management
*Please Describe your above selections:*

_____

**Section IV: Parent/Caregiver Support Needs** (Required for FPSS only)

The child/youth's family is available, receptive to and demonstrates need for improvement in the following areas such as but not limited to *(check all that apply)*:
☐ strengthening the family unit ☐ building skills within the family for the benefit of the child ☐ promoting empowerment within the family ☐ strengthening overall supports in the child's environment

*Describe:*

**Section V: Recommended CFTSS Services**

| *Service* | *Describe Service Needs (if known/applicable)* |
|---|---|
| ☐ Other Licensed Practitioner (OLP) | |
| ☐ Community Psychiatric Supports and Treatment (CPST) | |
| ☐ Psychosocial Rehabilitation (PSR) | |
| ☐ Family Peer Supports and Treatment (FPSS) | |

LPHA Printed Name and Degree: _____

LPHA Signature: _____ Date _____

NPI# _____ MMIS# (*LCSW, Pscyhiatrist, Psychologist, NP, RN only)* _____
*(if no NPI, leave blank)*