

**In-Home Family Treatment (H2011)
Re-authorization Instrument
Ver. 1/2007**

Child's Name: _____ Referring Agency: _____

Child's DOB: _____ FC/JJA Case Manager: _____

Date of Initial Authorization: _____ FC/JJA Case Manager Phone #: _____

Number of In-Home Family Treatment Sessions authorized initially: _____

Number of In-Home Family Treatment Sessions provided to date: _____

Name of person completing this form: _____

1. Has the Child's Diagnosis changed? YES NO

If Yes - Please list all Axis I and II diagnoses here:

Name of Agency where this diagnoses was made: _____

2. Is the youth continuing to experience functional impairment as a result of their mental illness in their current placement that requires a service to remedy the family problems which contribute to the symptoms of the mental illness or their functional impairment? YES NO

3. List the specific functional impairments that the youth is exhibiting (as it relates to their mental illness) that it is believed can best be impacted by In-Home Family Treatment:

4. List the specific family problems that are believed to be contributing to this child's emotional disturbance:

5. Date of most recent CAFAS Scores: _____

(must be less than 30 days old- follow Up CAFAS should utilize a 30 day time frame for rating the criteria):

Total Score: _____

Home: _____

School: _____

Behavior towards others: _____

Community: _____

Moods: _____

Self-Harm: _____

Substance Use: _____

Thinking: _____

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6. What progress has been made with the child and family through the use of In-Home Family Treatment since the previous request for authorization?

7. Please explain the ongoing need for In-Home Family Treatment and why it is believed to be the most effective treatment intervention at this time and what result it is believed this intervention will achieve:

FOR CMHCCC USE ONLY:

Request for re-authorization has been approved for _____ units

Request for re-authorization has not been approved for the following reasons:

Other Treatment Recommendations:

Date: _____

CMHC QMHP: _____