AUTHORIZATION FOR
COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT

This is to certify that:

Recipient's Name _____ Date _____

Medicaid Number _____

has been screened and determined to be in need of a comprehensive behavioral health assessment as outlined in the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook. The comprehensive behavioral health assessment will be provided by:

_____ (provider)

_____ _____
Community Based Care Representative Date

OR

_____ _____
Managed Care Plan Representative (or designee) Date

OR

_____ _____
Department of Juvenile Justice Representative (or designee) Date

AUTHORIZATION FOR COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT FOR CHILD IN SHELTER

This is to certify that:

Recipient's Name _____ Date of Referral _____

Medicaid Number _____ Shelter Name _____

Shelter Address _____

has been screened and determined to be in need of a comprehensive behavioral health assessment as outlined in the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook. The comprehensive behavioral health assessment will be provided by:

_____ (provider)

_____ _____
Department of Children and Families (or designee) Date

To be placed in recipient's clinical record.

AHCA Form 5000-3511, Revised March 2014 (incorporated by reference in Rule 59G-4.295, F.A.C.)