AUTHORIZATION FOR CRISIS INTERVENTION

This is to certify that:

Recipient's Name _____ Date _____

Medicaid Number _____

has been screened and recommended for Crisis Intervention by the multidisciplinary team.

This service will be provided by: _____ (provider agency) as authorized by:

The recipient is eligible for Specialized Therapeutic Foster Care as follows:

____ The recipient meets eligibility criteria for service.

____ Multidisciplinary team has determined the child is in need of the service.

_____ _____
Medicaid Area Office Representative (or designee) Date

Services will be authorized by the multidisciplinary team from: _____
Date

Services must be reviewed and reauthorized by the multidisciplinary team prior to _____
Date

Refer to policy in the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook for instructions on what must be completed for the specific service.

To be placed in recipient's clinical record. Medicaid reimbursement will cover certified dates, only.

AHCA Form 5000-3515, Revised March 2014 (incorporated by reference in Rule 59G-4.295, F.A.C.)