AUTHORIZATION FOR
THERAPEUTIC GROUP CARE SERVICES

This is to certify that:

Recipient's Name: _____ Date: _____

Medicaid Number: _____ Date of Birth: _____

has been determined by a multidisciplinary team as appropriate for therapeutic group care placement by a licensed clinical psychologist, per section 490, F.S., or a board certified psychiatrist in compliance with section 394.4781 or 39.407, F.S., and has an emotional disturbance or serious emotional disturbance.

These services are to be provided by: _____

_____ _____
Medicaid Area Office Representative (or designee) Date

Services will be reviewed and reauthorized by the multidisciplinary team prior to this date: _____

This form must be placed in recipient's clinical record. Medicaid will reimburse services only for the dates of service authorized on this form.

AHCA Form 5000-3521, Revised March 2014 (incorporated by reference in Rule 59G-4.295, F.A.C.)