HEALTH CHOICE CLINICAL REVIEW ADDENDUM

Fax to **(877) 339-8758**

Member (Patient): _____

Member Health Choice #: _____

County of Residence: _____

Service(s) being requested (include frequency/ intensity as appropriate):

Best number to reach you (the writer) for clarification: (_____) _____

Relationship of the guardian to the member (mother, father, DSS, etc)?

_____

CURRENT CLINICAL STATUS RELATED TO THE SERVICE REQUEST: *What do you see as the most significant behavioral /emotional problems for this member right now?*

Describe the patient's progress to date *and a*lso please note any clinical complexities that should be considered.

SCHOOL INFORMATION:

In what grade is the patient enrolled? _____

Does the member have an IEP or 504 Plan? ○YES ○NO, if yes, under what designation (B.E.D, L.D. etc). _____.

Is the patient placed in an Exceptional Children's Program classroom or other specialized educational setting? ○YES ○NO

Below, list the member's academic progress as well as any school behavioral problems including the history suspensions or expulsions.

Is the school involved in the treatment planning and implementation? ○ YES ○NO If yes, state how:

ABUSE HISTORY: Does the member have a history of being neglected, or physically, emotionally, or sexually abused? ○YES ○ NO If yes, describe.

Does the patient have a history of sexualized behaviors or sexual aggression *to others?*

○YES ○NO *If yes, describe.*
If there has been a sexual offender specific evaluation, please attach a copy.

LEGAL HISTORY: Does the member have any legal involvement?

○ YES ○ NO *(If so describe and note any DJJ involvement in the treatment process).*

HOME/COMMUNITY: Who is in home? Note relevant family dynamics or significant family issues.

Is the family engaged in the treatment process or willing to do so? ○ YES ○ NO

CURRENT MENTAL HEALTH SERVICES: Note **each service** the patient is currently receiving and the frequency, duration and intensity as appropriate. (For example, weekly individual therapy since May, 2005 or Community support preceded by CBS since December, 2005 at 10 hours a week).

Are there any further evaluations needed?

Has the member been involved and cooperative with the treatment process?

Note below any additional clinical information which you feel should be considered in determining the medical necessity and clinical appropriateness of your request.

PLEASE ATTACH THE CURRENT PERSON CENTERED PLAN. If this is not yet available please explain when this will be completed and attach the current updated treatment plan**.**

Thank you for taking the time to respond to all of the above questions. Your efforts at thoroughness will expedite the authorization process. Fax: (877) 339-8758