ABBOTT HOUSE

Children and Family Treatment Support Services (CFTSS)
Request for CFTSS Services Form

Request Date:	Child's Name (First/MI/Last)	DOB	Medicaid CIN#

Person Making Referral/Title:	Contact Number:
Referring Agency Name:	Contact Number:
Care Coordinator Name:	Contact Number:
Case Planner Name:	Contact Number:

Manage Care Company Name:	Contact Number:

Member ID#

Demographic Information for Child:

Gender	Address	City	State	Zip

School Name:	School Address
School Contact Name/Title:	School Contact Number:

Caregiver Information:

Name:	Primary Contact Number:	Second Contact Number

Address:	City	State	Zip

CONTINUE ON NEXT PAGE

ABBOTT HOUSE

Children and Family Treatment Support Services (CFTSS)
Request for CFTSS Services Form

Presenting Behaviors (Please Explain)

CFTSS Services Requested

***Please Note:**

- **Child must be Medicaid-eligible**
- **Services requested must meet Medical Necessity Criteria**
- **Must be recommended by an Other Licensed Practitioner (OLP)**
- **Must have MCO authorization**

☐ OLP (Other Licensed Practitioners) Medical Necessity

☐ OLP Licensed Evaluation / Assessment

☐ OLP Psychotherapy

☐ OLP Crisis Interventions

☐ CPST (Community Psychiatric Supports and Treatment)

☐ Psychosocial Rehabilitation

All Service Request forms must be submitted via:

Lower Hudson Valley: FAX: (914) 650-1242 or EMAIL: FLorusso@abbotthouse.net

New York City: FAX (917) 793-3645 or EMAIL: SColon@abbotthouse.net