

**AUTHORIZATION FOR
COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT**

This is to certify that

Child'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 Community Behavioral Health Services Coverage and Limitations handbook. The behavioral health comprehensive assessment will be provided by:

_____ (provider).

District Substance Abuse and Mental Health Representative Date

AND

District Family Safety or Community Based Care Representative Date

OR

District Juvenile Justice Representative Date

**AUTHORIZATION FOR COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT
FOR CHILD IN SHELTER**

This is to certify that

Child'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 Community Behavioral Health Services Coverage and Limitations handbook. The behavioral health comprehensive assessment will be provided by:

_____ (provider).

District Family Safety or Community Based Care Representative Date

To be placed in recipient's (child's) medical record.