

# AUTHORIZATION FOR CRISIS INTERVENTION

This is to certify that

Child's Name \_\_\_\_\_ Date \_\_\_\_\_

Medicaid Number \_\_\_\_\_

has been screened and recommended for Crisis Intervention.

This service will be provided by:

\_\_\_\_\_ (provider agency) as

authorized by:

\_\_\_\_\_  
District Substance Abuse and Mental Health Representative

\_\_\_\_\_  
Date

**AND**

\_\_\_\_\_  
District Children and Families or Community Based Care  
Representative

\_\_\_\_\_  
Date

**OR**

\_\_\_\_\_  
District Juvenile Justice Representative

\_\_\_\_\_  
Date

Services will be reviewed by the multidisciplinary team prior to \_\_\_\_\_.  
Date

Refer to policy in the Florida Medicaid Community Behavioral Health 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.**