

AUTHORIZATION FOR SPECIALIZED THERAPEUTIC FOSTER CARE

This is to certify that

Child's Name _____ Date _____

Medicaid Number _____

has been screened and recommended by a multidisciplinary team for Specialized Therapeutic Foster Care and has been determined to require the following level of service:

_____ Level I Specialized Therapeutic Foster Care

_____ Level II Specialized Therapeutic Foster Care

These services are to be provided by

_____ (provider agency) as authorized by:

District Substance Abuse and Mental Health Representative

Date

AND

District Family Safety or Community Based Care Representative

Date

OR

District Juvenile Justice Representative

Date

AND

Area Medicaid Representative

Date

Services will be reviewed and reauthorized 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 (child's) clinical record. Medicaid reimbursement covers only dates of service authorized on this form.