AUTHORIZATION FOR
THERAPEUTIC GROUP CARE SERVICES

This is to certify that:

Child's Name _____ Date _____

Medicaid Number _____ Date of Birth_____

has been screened by a multidisciplinary team or by a Qualified Evaluator, under Chapter 39.407, and determined to require and be suitable for Therapeutic Group Care Services:

These services are to be provided by _____
(provider agency)

as authorized by:

_____ _____
District Substance Abuse and Mental Health Representative Date

AND

_____ _____
District Child Welfare or Community Based Care Representative Date

AND

_____ _____
Medicaid Field Office Representative Date

Services will be reviewed and reauthorized by the multidisciplinary team prior

to this date: _____

This form must be placed in child's clinical record. Medicaid will reimburse services only for the dates of service authorized on this form.