

Questionnaire: Home and Community Based Treatment (HCT)

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1. *Is this request a new treatment/episode of care?*

(Please select one.)

- Yes
 No

2. *Determination of the appropriate level of care based on the Child/ Adolescent's Level of Functional Assessment Score*

(Please select one.)

- CAFAS CANS CASII CBCL PECFAS YOQ

If you answered "CANS" on question 2

2.3.1. *How many scores are two or higher in life domain functioning?*

2.3.2. *How many scores are two or higher in child behavioral/emotional needs?*

If you answered "YOQ" on question 2

2.7.1. *YOQ Score:*

2.7.2. *Who completed the YOQ?*

2.7.3. *Date YOQ completed:*

Instructions: Describe plan of how the units are going to be utilized by each discipline:

3. *Interventions of how the BHP units will be used:*

4. *Interventions of how the clinical units will be used:*

5. *Has this member received all authorized units of service during the last review period?*

(Please select one.)

- Yes
- No

If you answered "No" on question 5

5.2.1. *Why not?*

(Please select between 1 and 3 items.)

- Staff availability
- Family availability
- Illness

6. *Have a diagnosis of a serious emotional disturbance for one (1) year or likely to last more than one (1) year?*

(Please select one.)

- Yes
- No

7. *Is parent/guardian participating in the member's treatment?*

(Please select one.)

- Yes
- No

If you answered "No" on question 7

7.2.1. *Please explain*

8. *Has the Triple P modality been provided in the last authorization period?*

(Please select one.)

- Yes

Yes

No

9. *Does the provider intend to provide the Triple P modality in the next authorization period?*
(Please select one.)

Yes

No
