AUTHORIZATION FOR
COMPREHENSIVE BEHAVIORAL HEALTH ASSESSMENT

Date of Referral: _____

Child's Name: _____

DOB: _____ Medicaid Number: _____

Placement Location: _____

Location Address: _____

_____

Phone Number: _____

☐ Authorization for Comprehensive Behavioral Health Assessment for child in shelter

☐ Authorization for Comprehensive Behavioral Health Assessment for child in out of home care

_____

Child Welfare Case Manager or Child Protective Investigator Date

_____

Substance Abuse Mental Health Representative or Designee Date

☐ This is to certify that this child has been screened and determined to be in need of a Comprehensive Behavioral Health Assessment (W1059) as outlined in the Medicaid Community Mental Health Coverage and Limitations handbook. The Comprehensive Behavioral Health Assessment will be provided by:

_____

Provider Assigned

*This form is to be placed in recipient's (child's) medical record

Comment [d1]: Pre-fills with today's date.

Comment [d2]: Pre-fills with the Child's Name on the Medical Mental Health page.

Comment [d3]: Pre-fills from the Child's Person Management Record.

Comment [d4]: Pre-fills from the Child's Person Management Record with the Primary Medicaid Number.