

FUNDING APPROVAL REQUEST PACKET - COVER PAGE & CHECKLIST (9/08)

(This form is to be completed each quarter and attached to the front of the FAR packet)

Case# _____ Current Quarter: 7/1-9/30 10/1-12/31 1/1-3/31 4/1-6/30 Year: _____

Case Manager: _____ Agency: _____ Jurisdiction: Charlottesville Albemarle

Primary Child: _____ DOB: _____ Race: _____

Social Security #: _____ Gender: Male Female Hispanic: Yes No

Name of Child's Current Placement or Home Address: _____

Child's Placement Type (choose one):

- Psychiatric hospital/Crisis stabilization unit
- Residential facility/Group home/Temporary care facility
- Treatment foster care program (e.g. Depaul, People Places)
- Specialized TAFF home/Community Attention (FGH) foster family home
- Non-specialized TAFF home
- IL arrangement
- Own home (living w/ parent, relative, or guardian)

CSA PRIMARY MANDATE TYPE (choose one):

- Foster Care Abuse/Neglect - Prevention
- Foster Care Abuse/Neglect – DSS Non-custodial agreement
- Foster Care Abuse/Neglect – Local DSS Entrustment/Custody
- Foster Care Child in Need of Services (CHINS) - Prevention
- Foster Care Child in Need of Services (CHINS) – CSA Parental agreement
- Foster Care Child in Need of Services (CHINS) – Entrustment/Custody
- Foster Care - Court Ordered for truancy
- Foster Care - Court Ordered for delinquent behaviors
- Special Education- Services in the public school (to prevent more restrictive/expensive educational placement)
- Special Education services in an approved educational placement
- Non-Mandated

Is the child special education eligible? Yes No

Does the child have a diagnosis of Autism, PDD NOS, or Asperger's? Yes No

Does child have a DSM IV mental health diagnosis? Yes No

Does the child have medications for a Mental Health problem ordered by a physician? Yes No

Is the child Medicaid enrolled? Yes No

IV-E ELIGIBILITY STATUS (Foster Care cases only): N/A Eligible Denied Pending Closed

PARENT/FAMILY INCOME INFO* (required for Non-mandated and Foster Care Prevention cases only):**

Parent Name(s): _____ Phone #: _____

Address: _____

Gross Monthly Income: \$ _____ Number Dependent on Income: _____

Has family been informed they may be contacted by CSA Coordinator about a co-pay fee? Yes No

Comments: _____

***If the Parental Income section is required, a copy of this Cover Page/Checklist along with the Consent for Release of Information form will be forwarded to the CCF office to determine possible co-pay responsibility.

PREPARER/REVIEWER'S CHECKLIST ITEMS

- CANS Completed/Updated** **Date of most recent CANS:** _____
- MDT Log Updated/Attached**
- Current Consent for Release of Confidential Information Attached** *(required for all cases, updated annually)*
- Foster Care Prevention Addendum Updated/Attached** *(required for non-FAPTed FC prevention cases only)*
- Under Threshold Addendum Updated/Attached** *(required for non-FAPTed cases only)*
- Pre-Placement UR Consultation Initiated for Non-Medicaid Residential Placement** *(if applicable)*
- Medicaid Funding Initiated** *(Justification(s) have been provided on Under Threshold Addendum if applicable; CON initiated if Residential; In-home Medicaid screening form completed if applicable.)*
- Progress Report Received as Required** *(at least quarterly)*
- Out of Jurisdiction Form Completed/Attached***** *(if applicable)*

*****If the Out of Jurisdiction box is checked above, a copy of this Cover Page/Checklist along with the Consent for Release of Information form and the Out of Jurisdiction form will be forwarded to the CCF office.**

UTILIZATION REVIEW SCREENING CRITERIA***

- The client is receiving in-home therapy services of more than five hours a week extending beyond six months.
- The client has had two disrupted placements within a six month period.
- The client has remained placed in a secure setting for more than twelve consecutive months.
- The client has remained placed outside the Charlottesville/Albemarle community in a non-family setting for more than eighteen months.
- The client will be transitioning back into the community after placement outside the Charlottesville/Albemarle community in a non-family setting for more than eighteen months.
- The client is a IV-E eligible foster child, and the combined total of the monthly CSA and IV-E costs puts the case over the funding threshold.

*****If any of the above UR Screening boxes are checked, a copy of this Cover Page/Checklist along with the Under Threshold Addendum form (if applicable); and the Consent for Release of Information form will be forwarded to the CCF office for further Utilization Review.**

Case Manager Signature: _____ **Date:** _____

Supervisor: _____ **Date:** _____

CPMT Designee Signature: _____ **Date:** _____