|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **YOUTH INFORMATION:** | | | | |
| Autism Spectrum Disorder: | Yes  No | | Special Education Eligible: | Yes  No |
| Child DSM Diagnosis: | Yes  No | | Active in Probation or Diversion: | Click to select item. |
| Child Mental Health Meds: | Yes  No | | Currently being served by Foster Care/ CPS or have in the last year: | Click to select item. |
| Race: | Click to select item. | | Hispanic Origin: | Yes  No |
| **INSURANCE INFORMATION:** | | | | |
| **Medicaid Status:** Does youth have Medicaid?Choose an item. | | | | |
| **Insurance Status:** Does youth/family have private insurance? Yes  No  *If yes, please explain why insurance is not being utilized for requested service(s):*Click or tap here to enter text. | | | | |
| **BACKGROUND INFORMATION: (INITIAL REQUESTS ONLY)** | | | | |
| **Please specify the needs to be addressed by the services requested below (reference 2s and 3s on the CANS). Include services that have been previously utilized:** Click or tap here to enter text. | | | | |
| **UPDATES (FOR RE-AUTHORIZATION REQUESTS ONLY):** | | | | |
| **Please specify the needs to be addressed by the services requested below (reference 2s and 3s on the CANS). Describe how these services will be used and by whom.** Click or tap here to enter text. | | | | |
| **TREATMENT TEAM PLAN TO TRANSITION TO LESS INTENSIVE SERVICES AND INCREASE USE OF NATURAL SUPPORTS:** | | | | |
|  | | | | |
| **COMMUNITY-BASED SERVICES REQUESTED:** | | | | |
| **Service:** | | | | |
| New/Existing | | Choose an item. | | |
| Service | | Click or tap here to enter text. | | |
| Can Medicaid be used?  *(Only complete if youth has Medicaid)* | | Choose an item.  *If, Medicaid eligible but unavailable/inaccessible please explain:* Click to enter text. | | |
| For Whom: | | Click or tap here to enter text. | | |
| Provider *(if known)* | | Click or tap here to enter text. | | |
| Frequency/Hours | | Click or tap here to enter text. | | |
| Service Length/Dates | | Click or tap here to enter text. | | |
| **Service:** | | | | |
| New/Existing | | Choose an item. | | |
| Service | | Click or tap here to enter text. | | |
| Can Medicaid be used?  *(Only complete if youth has Medicaid)* | | Choose an item.  *If, Medicaid eligible but unavailable/inaccessible please explain:* Click to enter text. | | |
| For Whom: | | Click or tap here to enter text. | | |
| Provider *(if known)* | | Click or tap here to enter text. | | |
| Frequency/Hours | | Click or tap here to enter text. | | |
| Service Length/Dates | | Click or tap here to enter text. | | |
| **Service:** | | | | |
| New/Existing | | Choose an item. | | |
| Service | | Click or tap here to enter text. | | |
| Can Medicaid be used?  *(Only complete if youth has Medicaid)* | | Choose an item.  *If, Medicaid eligible but unavailable/inaccessible please explain* Click to enter text. | | |
| For Whom: | | Click or tap here to enter text. | | |
| Provider *(if known)* | | Click or tap here to enter text. | | |
| Frequency/Hours | | Click or tap here to enter text. | | |
| Service Length/Dates | | Click or tap here to enter text. | | |

**Signatures**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Case Manager’s Name |  | Case Manager Signature |  | Date |
|  |  |  |  |  |
| Supervisor’s Name |  | Supervisor’s Signature |  | Date |