



ABBOTT HOUSE

Children and Family Treatment Support Services (CFTSS) Request for CFTSS Services Form

Request Date:	Child's Name (First/MI/Last)	DOB	Medicaid CIN#
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Person Making Referral/Title:	Contact Number:
Referring Agency Name:	Contact Number:
Care Coordinator Name:	Contact Number:
Case Planner Name:	Contact Number:

Managed Care Company Name:	Contact Number:
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Member ID#

Demographic Information for Child:

Address	City	State	Zip
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School Name:	School Address
School Contact Name/Title:	School Contact Number:

Caregiver Information:

Name:	Primary Contact Number:	Second Contact Number
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Address:	City	State	Zip
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Presenting Behaviors (Please Explain)

CFTSS Services Requested

*Please Note:

- **Child must be Medicaid-eligible**
- **Services requested must meet Medical Necessity Criteria**
- **Must be recommended by an Other Licensed Practitioner (OLP)**
- **Must have MCO authorization**

- OLP (Other Licensed Practitioners)
- Licensed Evaluation / Assessment
- Treatment Planning
- Psychotherapy
- Crisis Interventions
- CPST (Community Psychiatric Supports and Treatment)
- Psychosocial Rehabilitation

All Service Request forms must be submitted via:

Lower Hudson Valley: FAX: (914) 650-1242 or EMAIL: ServicesReferral-LHV@abbotthouse.net

New York City: FAX (917) 793-3645 or EMAIL: ServicesReferral-NYC@abbotthouse.net