FAX TO: **Optum Public Sector San Diego**
Fax: (866) 220 – 4495
Phone: (800) 798-2254, Option 3, then Option 4

County of San Diego Mental Health Plan
Therapeutic Foster Care (TFC) Prior Authorization Request - Through FFAST

☐ Prior Authorization Request (Prior to provision of TFC)

☐ Continuing Request (After initial authorization of up to 12 months)

Client Information

Client Name:	Date of Birth:	Client ID:

Foster Family Agency Stabilization and Treatment (FFAST) Information

Legal Entity: San Diego Center for Children		Program Name: FFAST
Phone: 858-633-4115		Fax: 858-737-6972
Unit #: 6980	Subunit #: 6986	Program Manager Name: Aisha Pope

SCOPE OF SERVICE:

Therapeutic Foster Care is a short-term, intensive, highly coordinated, trauma- informed, and individualized intervention, provided by a TFC parent to a child or youth who has complex emotional and behavioral needs, documented with service code Therap Foster Care – TFC (94).TFC services are available to Katie A subclass members as well as beneficiaries under 21 who are eligible for the full scope of Medi-Cal services, meet medical necessity criteria and are receiving Intensive Care Coordination. A Child and Family Team must be identified in order to provide TFC. TFC is intended for children and youth who require intensive and frequent mental health support in a family environment.

TFC Criteria: (Items 1-5 are required for authorization of TFC)

1. ☐ **Client is under the age of 21**
2. ☐ **Intensive Care Coordination (ICC): Client is eligible for and receiving ICC services.**
   (Not eligible for TFC unless receiving ICC)
3. ☐ **Client has a CFT in place to guide TFC service provision. Most recent CFT meeting date: _____**
   (Not eligible for TFC unless a CFT is in place)
4. ☐ **Client meets medical necessity criteria for Specialty Mental Health Services BHIN 21-073 as documented in: (select all that apply)**
   - ☐ **Behavioral Health Assessment (BHA) dated: _____**
   - ☐ **DSM/ICD Mental Health diagnosis: _____**
   - ☐ **Progress/CFT Note dated: _____**
   - ☐ **Other: _____**

5. ***The following are clinical indicators of need and are not requirements or conditions for TFC services - per Medi-Cal Manual Third Edition, Chapter 2 "Target Population":*** (Check at least 1)
   Client is at risk of losing their placement and/or being removed from their home as a result of the caregiver's inability to meet the client's mental health needs; and, either:
   - ☐ **There is a recent history of services and treatment (for example, ICC and IHBS) that have proven insufficient to meet the client's mental health needs, and the client is immediately at risk of residential, inpatient, or institutional care; or**
   - ☐ **Client is transitioning from a residential, inpatient, or institutional setting to a community setting, and ICC, IHBS, and other intensive SMHS will not be sufficient to prevent deterioration, stabilize the client, or support effective rehabilitation; or**
   - ☐ **Not applicable, TFC need is based on meeting criteria #1-4 above.**

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TFC FREQUENCY AND DURATION REQUEST:

1. **Amount Requested:**
   ☐ **Up to 7 days of TFC intervention per week**
2. **Duration Requested:**
   ☐ **Up to 12 months of TFC intervention**

FOR USE BY OPTUM ONLY/AUTHORIZATION DETERMINATION

☐ **OPTUM Reviewed BHA, Client Plan and/or Progress Notes**

☐ **TFC scope, amount and duration authorized as requested: START DATE: _____END DATE: _____**

☐ **TFC request is ☐ denied; ☐ modified; ☐ reduced; ☐ terminated; or ☐ suspended**

Reason: _____

NOABD was issued to the Medi-Cal beneficiary and provider on the following date: _____

Optum Clinician Signature/Date/Licensure:

Within five business days of Optum receipt, authorization will be forwarded to the requesting provider