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Questionnaire: Home and Community Based Treatment (HCT)

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1. Has member scored a Level 3 or higher on the age-appropriate Level of Care/Service Intensity tool completed by the Department or its Authorized Entity?
   (Please select one.)
   - ○ Yes
   - ○ No

   1.1.1.Please Provide Score

   1.2.1.Please Provide Score

2. Is this request a new treatment/episode of care?
   (Please select one.)
   - ○ Yes
   - ○ No

3. Please explain significant functional impairment (defined as a substantial interference with, or limitation of, a member's achievement or maintenance of one or more developmentally appropriate, social, behavioral, cognitive, or adaptive skills)

Instructions: Describe plan of how the units are going to be utilized by each discipline:

4. Interventions of how the BHP units will be used:

5. Interventions of how the clinical units will be used:

6. Is the child fully staffed with a clinician?
   (Please select one.)
   - ○ Yes
   - ○ No

   6.2.1.Please explain

7. Is the child fully staffed with a BHP?
   (Please select one.)
   - ○ Yes
   - ○ No

   7.2.1.Please explain

8. Have a diagnosis of a serious emotional disturbance for one (1) year or likely to last more than one (1) year?
   (Please select one.)
   - ○ Yes
   - ○ No

9. Is parent/guardian participating in the member's treatment?
   (Please select one.)
   - ○ Yes
   - ○ No

   9.2.1.Please explain

10.Has the Triple P modality been provided in the last authorization period?
(Please select one.)

- ○ Yes
- ○ No

11.Does the provider intend to provide the Triple P modality in the next authorization period?
(Please select one.)

- ○ Yes
- ○ No