**UR Date: select date Client Name: last, first**

**(Locality Name)**

**Utilization Review Addendum to the IFSP**

|  |
| --- |
|  ***Demographic Information:***  |
| **Client Name:** (first middle last) | **Client ID #:** (\_) | **DOB:** (select date) | **Age:** . |
| **Review Date:** (select date) |  **Last Review Date:** (select date) | **Reporting Period:** (select) |
| **Service Provider:** (provider name) | **Admission Date:** (select date) |
|  **Date of Most Recent CANS:** (select date) | **Date of last FAPT:** (select date) |
|  |
| ***Evaluations/Diagnoses/Medications*** |
| **Evaluations:**(Include name/date of assessment and results.) |
| ***Diagnoses*:** (DSM-5) |
| **Medications:** (Include medication type, dosage, frequency, and prescribing doctor.) |
|  |
| ***Historical Information*** |
| **Case History:** (Include all relevant information.) |
| **Service History:** : (therapeutic, psychiatric, hospitalizations, educational, etc.) |
| **Rationale for Current Services:** (Include rationale for services including mitigating circumstances.) |
|  |
| ***Youth and Family Strengths*** |
| **Per the Youth:** (In the youth’s own words.) |
| **Per the Family:** (In the family’s own words.) |
| **Per the Case Manager (CANS):** (Strengths as identified in the CANS.)  |
| **Per FAPT (IFSP):** (Strengths as identified in the IFSP.) |
| **Per the Provider:** (Strengths as identified in the provider’s service plan.) |
|  |  |
| ***Youth and Family Needs and Treatment Concerns*** |
| **Per the Youth:** (In the youth’s own words.) |
| **Per the Family:** (In the family’s own words.) |
| **Per the Case Manager (CANS):** (Needs as identified in the CANS.)  |
| **Per FAPT (IFSP):** (Needs as identified in the IFSP.) |
| **Per the Provider:** (Needs as identified in the provider’s service plan.) |
|  ***Service Plan Review:*** |
| **Date of most recent treatment team:** (select date)**Did youth participate?** [ ] Yes [ ]  No**Did parent/guardian participate?** [ ]  Yes [ ] No; if yes, [ ]  in person or [ ] by phone**Did case manager participate?** [ ] Yes [ ] No; if yes, [ ]  in person or [ ] by phone |
|  ***Goals & Objectives:*** |
| ***Family Goal:*** |
| (What is the family’s overall desired outcome?) |
| ***IFSP Goals/Objectives*** | ***Service Plan Goals/Objectives*** |
| **Goal/Objective 1:**(goal/objective #1) | **Goal/Objective 2:**(goal/objective #1) |
| **Progress:** (progress) | **Progress:** (progress) |
| **Goal/Objective 2:** (goal/objective #2) | **Goal/Objective 2:** (goal/objective #2) |
| **Progress:** (progress) | **Progress:** (progress) |
| **Goal/Objective 3:**(goal/objective #3) | **Goal/Objective 3:**(goal/objective #3) |
| **Progress:** (progress) | **Progress:** (progress) |
| **Goal/Objective 4:** (goal/objective #4) | **Goal/Objective 4:**(goal/objective #4) |
| **Progress:** (progress) | **Progress:** (progress) |

|  |
| --- |
| ***Discharge Plan/Progress Toward Discharge:*** |
|  **Discharge to:** (What is the next LRE?) | **Proposed Discharge Date:** (select date) |
| **Family’s involvement in discharge:** Describe the family’s involvement in discharge planning (home visits, identification of needs for step down, engagement in therapy, etc.). |
| **Summarize discharge planning efforts:** (services, community resources, educational plan, etc.) |
|  |
| ***Recommendations:*** |
| (Recommendations to include treatment needs and corresponding services/resources for the youth and family?) |

|  |
| --- |
| ***Next Review Date:*** |
| (select date): |

|  |
| --- |
|  ***Review Completed By:*** (name and title) |