The HealthPlan

REQUEST FOR CFT PROGRAMMING

Member Name:	Date of Request:
Member ID:	Date of Birth:
Provider/Facility Name:	
Program Name:	Contact Phone Number:
Address:	
Physician Overseer:	
Diagnosis:	ICD-10:
Diagnosis:	ICD-10:
Diagnosis:	ICD-10:
Diagnosis:	ICD-10:
Diagnosis:	ICD-10:
CPT Code Requested:	

NEEDS LIST:	Yes	No	N/A
Master Plan completed	☐	☐	☐
Symptoms Mild	☐	☐	☐
Symptoms Moderate	☐	☐	☐
Symptoms Severe	☐	☐	☐

NEEDS LIST:	Yes	No	N/A
Inadequate support system	☐	☐	☐
Needs assistance for successful outcome to perform ADLs without structure	☐	☐	☐
Inappropriate for day treatment program	☐	☐	☐
Efforts made to link to natural supports/activities/services in the community	☐	☐	☐

LIST IDENTIFIED GOALS:

PROGRESS TOWARD PROGRAM OBJECTIVES AND FUTURE PLANNING:

NEWLY IDENTIFIED AREAS OF NEED:

REVIEWED 08/23/2018