



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	NEEDS LIST:	Yes	No	N/A
Master Plan completed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inadequate support system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Symptoms Mild	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Needs assistance for successful outcome to perform ADLs without structure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Symptoms Moderate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Inappropriate for day treatment program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Symptoms Severe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Efforts made to link to natural supports/activities/services in the community	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

LIST IDENTIFIED GOALS:



PROGRESS TOWARD PROGRAM OBJECTIVES AND FUTURE PLANNING:

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NEWLY IDENTIFIED AREAS OF NEED:

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REVIEWED 08/23/2018