## **Office of Children’s Services**

##  **State Sponsored Utilization Review**

# Initial Utilization Review

|  |  |
| --- | --- |
| **Client:** | **DOB/Age:** |
| **Social Security #:** | **CSA Contact Person:** |
| **CSA Locality:** |  |
| **Service Provider:** | **Admission Date:** |
| **Reporting Period:****Date of Most Recent CANS Administration:** | **Review Date:** |

**Case History and Reason for Placement:**

**Diagnosis (if available):**

**Psychological Evaluation Findings (if available):**

**Current Medications:**

**Services Utilized in the Past:**

**Client and Family Strengths:**

**Treatment Concerns/Challenges:**

**SERVICE PLAN REVIEW (includes Foster Care Plan, if applicable)**

Include description and notes related to progress or lack of progress for each goal:

|  |  |
| --- | --- |
| **IFSP Goals/Objectives** | **Service Provider Goals/Objectives** |
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |
| 4. | 4. |
| 5. | 5. |

### Is the local CSA case manger participating in Service Planning/Treatment Team meetings with the service provider?

**If so, how?**

**Is service provider participating in FAPT Meetings? If so, how?**

**Discharge Plan:**

**Contacts with Locality by UR Consultant:**

Name:

Date:

Content:

**Consults (Magellan, DBHDS professional) by UR Consultant:**

Name:

Date:

Content:

**Recommendations:**

**Utilization Review Consultant:**

**Next Review Date:**

**CC:** CPMT Chair