Initial and Monthly Behavioral Health Assessment

STAR Health

Please complete the form below and fax with coversheet to: 1-866-274-5952

Provider Information

Provider Name: __________________________ **Group/Agency Name**:_______________ **NPI:** ____________ **Tax ID:** __________

Provider Type: Psychologist Psychiatrist Counselor Other **Phone Number:** _______________ **Fax Number:** __________

Please indicate the type of service provided:

Individual Therapy Family Therapy Group Therapy In-Home Therapy Medication Management Other type of therapy

If Other type of therapy is selected, please describe: ____

Frequency of visits per month: ________________________________ **Date last seen:** _______________

Member Information

Member Name:___________________________ **Medicaid ID:** _____________________ **Date of Birth:** ________________

Type of Assessment: Initial Clinical Summary Monthly Clinical Summary

DFPS Level of Care: Basic Moderate Specialized Intensive

Current Placement: Shelter Foster Home Kinship Placement No Placement Identified Waiver or HCS Home

Transitional Living (Aged Out) RTC (*If member is in an RTC include admission date*): ______________________________

Child Permanency Plan *(If Known)***:** Reunification with family Remain in DFPS Custody Kinship Placement Adoption Other

Member's Diagnosis Information:

Primary:

Secondary:

Tertiary:

Additional Diagnoses:

Clinical Summary

Brief narrative summary of clinical visits since last update:

Medical conditions that may be impacting Member's behavioral health:

Significant changes since the last update (including but not limited to, new symptoms, psychological testing, or hospitalization):

Assessments completed and outcome scores, if applicable:

Treatment Goals:

Evaluation of Member's progress:

Referrals to other providers or community resources:

Any other relevant care information: