HEALTH SYSTEMS

CAT Extension/Readmission Authorization Form

**If extension request, forms must be submitted at least 30 days prior to consumer's anticipated discharge date*

**If readmission request, enter N/A for all fields and complete "Readmission Justification" section only*

Provider Name: _____ **Date**: _____

Consumer Information:	
Name:	
DOB:	SSN:
Treatment Details: *(If readmission request, skip to "Readmission Details" Section)*	
Date of CAT Admission:	
Length of Extension Time Requested: ◉ 1 Month ○ 2 Months ○ 3 months	
Discharge Date if Extension is Approved:	
Current CAT Treatment Plan Goals and Progress:	
Goal:	○ Completed ○ Not Completed
Goal:	○ Completed ○ Not Completed
Goal:	○ Completed ○ Not Completed

Evidence Based Practices (EBP) Utilized during CAT Treatment:

☐ Cognitive-Behavioral Therapy ☐ Wraparound ☐ Motivational Interviewing ☐ Dialectical Behavior Therapy ☐ Trauma Focused Cognitive Behavioral Therapy ☐ Solution Focused Brief Therapy ☐ EMDR ☐ Child Parent Relational Therapy ☐ WRAP ☐ Other_____

Client Symptoms Requiring Continued CAT Treatment:

Family's Level of Engagement During CAT Treatment:

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Challenges/Barriers During CAT Treatment:
Specific CAT Interventions that Will be Implemented During the Requested Extension Period:
Current CAT Discharge Plan Recommendations Following Extension Period: ☐ Outpatient Therapy ☐ Case Management ☐ Behavioral Analyst ☐ Psychiatric Services ☐ Mentoring ☐ FSPT ☐ Other_____
Readmission Details:
Readmission Justification:

[Please submit all CAT Extension/Readmission Authorization requests to your Network Manager and Meghan Riley-Reynolds, Children's System of Care Manager via encrypted email.**]**

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Contact Information:			
Agency Representative (Enter Name of Contact Person)	Phone	Fax	Email
LSF Health Systems Network Manager	904-900-1075	904-900-1628	NM:
LSF Health Systems Children's System of Care Manager - Meghan Riley-Reynolds	904-510-4802	904-900-1628	meghan.rileyreynolds@lsfnet.org
Provider Contact Name:			
Parent/Guardian Name (if applicable):			

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Provider Representative Signature

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LSF Health Systems Signature, **Authorizing** ***extension/readmission***