AUTHORIZATION FOR
SPECIALIZED THERAPEUTIC FOSTER CARE

This is to certify that:

Recipient's Name: ____ Date: ______________

Medicaid Number: ______________________

has been screened and recommended by a multidisciplinary team for specialized therapeutic foster care and has been determined to require the following level of service:

______ Level I Specialized Therapeutic Foster Care

______ Level II Specialized Therapeutic Foster Care

These services are to be provided by: ______________________ (provider agency), as authorized by:

The recipient is eligible for Specialized Therapeutic Foster Care as follows:

____ The recipient meets eligibility criteria for service.

____ Multidisciplinary team has determined the child is in need of the service.

____ ______________

Medicaid Area Office Representative (or designee) Date

Services will be reviewed and reauthorized by the multidisciplinary team prior to: ______________

Date

Refer to policy in the Florida Medicaid Specialized Therapeutic Services Coverage and Limitations Handbook for instructions on what must be completed for the specific service.

To be placed in recipient's clinical record. Medicaid reimbursement covers only dates of service authorized on this form.