PBH High Risk Staffing Form

Consumer: Date of Staffing: ____________________________
Consumer's Date of Birth:: __________________ County of Residence: ____
Current Diagnosis (Axis I-IV): ____
____

Community Support Worker/Agency: ___________________________________

Update since last TAR submission:
- ☐ Placements____
- ☐ Hospitalizations ____
- ☐ Treatment (involvement/changes) ____
- ☐ Home visits ____
- ☐ School (behavior; changes etc) ____
- ☐ DJJ involvement ____
- ☐ Medication(s) ____
- ☐ Diagnosis (to include updates to Axis I-V)____

Date of last Child and Family Team____
List who attended this meeting: ____

Long Term Plan for Consumer: ____
____
____

Please have guardian sign and date to indicate their approval of the information presented as well as the long term plan.

Guardian signature/date: ____

THE ABOVE INFORMATION SHOULD BE COMPLETE BEFORE THE HIGH RISK STAFFING

Please note: Treatment recommendations ***does not*** in any way imply the service will be approved by PBH Utilization Management (UM) department. PBH providers are responsible for providing UM with documentation necessary to meet medical necessity. Staffing with this team ***does not*** indicate PBH's endorsement of this recommended level of care.

Recommendations:
- ☐ Provider to pursue treatment authorization for the following service(s)

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- ☐ Consumer has declined services at this time
- ☐ Consumer's needs are currently being met or can be met with lower level services

  Explain:____
- ☐ Other: ____

Task to be Completed	Person Assigned and Due Date

Staff Signatures/Agency and Date:

________________________ ________________________
________________________ ________________________
________________________ ________________________
________________________ ________________________
________________________ ________________________