Behavioral Health Multi-Disciplinary Team (MDT) Meeting Note **MDT Meeting Date**:

Member's Name: _____ Date of Birth: _____ Medicaid ID#: _____

Gender Identification: _____ FSFN Person ID#: _____ FSFN Case ID#: _____

Type of MDT: ☐ Initial ☐ Subsequent ☐ Other: _____ Last MDT Date: _____

Admission Date into Treatment Services (if applicable): _____

Anticipated Discharge Date (if applicable): _____ Authorization Expiration Date (if applicable): _____

CURRENT PLACEMENT AND LEVEL OF CARE/TREATMENT							
Type		*Provider/Program/Agency*	*Level of Care/Treatment Services*				
☐	Foster Home		☐	STFC Level I	☐	Outpatient (Individual)	
☐	Therapeutic Home		☐	STFC Level II	☐	Outpatient (Group)	
☐	Group Care		☐	STFC Crisis	☐	TBOS	
☐	Therapeutic Group		☐	STGC/STGH	☐	BHOS	
☐	Residential Facility		☐	SIPP	☐	Other:	
☒	Other:		☐	Residential Treatment (RTC)	☐	n/a	

Medicaid plan: _____ Secondary/Other Insurance: _____

Eligible for SSI: ☐ Yes ☐ No APD Involvement: ☐ Yes ☐ Applied

Permanency Status: ☐ Reunification ☐ Permanent Guardianship ☐ Adoption ☐ APPLA ☐ Other: _____

CPA: Yes No Description if Yes: _____

Reason for Entry into Foster Care System: _____

School: _____ Grade Level: _____ History of Repeating Grades: ☐ Yes ☐ No

Current Academic Services: ☐ Exceptional Student Education ☐ Psychological Testing ☐ Other: _____
☐ 504 ☐ IEP ☐ EBD ☐ Full Scale IQ _____

Behaviors in school(s):	

TREATMENT HISTORY

Provider Name: _____ Treatment Dates: _____ - _____

Level of treatment _____

Discharge reason
If Current services
Date of *Last* Treatment Plan/Treatment Plan Review: _____ Date of *Next* Treatment Plan Review: _____

Provider Name: _____ Treatment Dates: _____ - _____

Level of treatment _____

Discharge reason: _____

Provider Name: _____ Treatment Dates: _____ - _____

Level of treatment _____

Discharge reason: _____

Behavioral Health Multi-Disciplinary Team (MDT) Meeting Note **MDT Meeting Date**:

Member's Name: Date of Birth: Medicaid ID#:

Comment(s):	

Mental Health Diagnosis/es:

Cognitive Functioning/ASD:

DJJ Involvement/History:

Substance Abuse Issues/History:

Inpatient Hospitalization/Last 12 Months:
(Psychiatric-Suicidal /Homicidal Ideation)

Current Presentation and Mental Health Status:	

Please indicate any current symptoms: ☐ No Current Symptoms

	Symptom	*Frequency/Duration*		*Symptom*	*Frequency/Duration*
☐	Auditory/Visual Hallucinations		☐	Animal Cruelty	
☐	Delusions		☐	Difficulty with Activities of Daily Living	
☐	Eating Disorder		☐	Elopement	
☐	Enuresis/Encopresis		☐	Extreme Impulsivity	
☐	Fire setting		☐	Homicidal Ideation and/or Gestures	
☐	Impaired Self-Concept		☐	Lying	
☐	Nightmares or Sleep Issues		☐	Physical and/or Verbal Aggression	
☐	Property Destruction		☐	Self-Destructive	
☐	Self-Injurious		☐	Sexualized Behaviors/Activities/Deviance	
☐	Stealing		☐	Substance Abuse	
☐	Suicidal Ideation and/or Gestures		☐	Compulsive Food behaviors	

Additional Comments and/or Explanation of Symptoms:	

Strengths:

Challenges:

PROVIDER/TREATMENT INFORMATION			
Evaluation	**Date of Last Evaluation**	**Date of Next Evaluation**	**Not Applicable**
Psychiatric Evaluation			☐
Psychological Evaluation			☐
Neuro-Psychological Evaluation			☐
Evaluation (Other):			☐
Evaluation (Other):			☐

MEDICAL INFORMATION/MEDICATION HISTORY

Primary Care Physician:		Psychiatrist/ ARNP:	
Current Medical Conditions:			

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Prescribed Medication (Dosage and Frequency): Was 5339 Completed?	

BH MDT Level of Care Recommendation(s)

☐ STFC Level I ☐ No recommendation for a higher level of care
☐ STFC Level II ☐ Other: _____

Is a Suitability Assessment Needed? ☐ Yes ☐ No Has one been completed? ☐ Yes ☐ No

☐ Initial	Date: _____	Recommendation:	☐ STGC/STGH	☐ SIPP	☐ Alternative
☐ 90 Day Review	Date: _____	Recommendation:	☐ STGC/STGH	☐ SIPP	☐ Alternative
☐ Reconsideration	Date: _____	Recommendation:	☐ STGC/STGH	☐ SIPP	☐ Alternative

Next Suitability Assessment Due Date: _____

Comment(s):	

DISCHARGE PLANNING ACTIVITIES

ADDITIONAL MDT RECOMMENDATIONS AND FOLLOW-UP ITEMS

Action Item/Recommendation	*Responsible Party*	*Target Date for Completion*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Next MDT Date: _____

Participant	Role	Agency	In attendance
	Dependency Behavioral Health Care Coordinator	NWF Health	☐
			☐
			☐
			☐

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			☐