



BEACON HEALTH STRATEGIES
EXTENDED FAMILY STABILIZATION SERVICES

Provider Information

Provider ID# _____ Provider Name and Site Location _____
Provider Phone # _____ FST Clinician _____
Contact/Supervisor _____

Member Information

Member Name: _____ Date of Birth ____/____/____
Health Plan: NHP Fallon Member ID# _____

Diagnosis (Refer to DSM IV) Axis I: _____
Axis II: _____
Axis III: _____
Axis IV: _____
Axis V: HGAF _____ LGAF _____ CGAF _____

Any Agency involvement? DSS DYS DMH DMR Court Other _____
If there is Agency involvement, please describe their involvement to date: _____

PCP: _____ Has the PCP been contacted?: _____ Y _____ N
If not, when is your plan to contact the PCP? _____

Please Describe the Member's Current Mental Status or Symptoms. Please be sure to note if there are any Current Risk Issues present: _____

Current Barrier(s) to Member's Transitioning to Routine/Traditional Outpatient Services: _____

Specific Treatment Plan to Address each Individual Barrier Listed Above: _____
(For example, FST plans on setting up a meeting with the school and parents to address member's educational difficulties in school.) _____

Family Stabilization Team Extended Care Review Form

FOR BEACON USE ONLY: BEACON CLINICIAN _____ DATE REVIEWED _____
REQUEST APPROVED _____ DENIED _____

