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? o DSS o DYS oDMH oDMR o Court oOther _____
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** _____

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Current Medications: **Name** **Dosage and Frequency**

Brief Summary of Family's Involvement in FST Services to Date: _____

_____

_____

_____

What Clinicians and Agencies will the Member and/or Family be Following Up with upon Terminating with FST Team? _____

_____

_____

_____

_____

Extension requests are due 5-7 days before current authorization ends.
Extensions may be requested in 1 to 3 week increments.

Dates of Service: From: ____/____/_____ To: ____/_____/____

Number of units requested: