SHORT TERM STABILIZATION CERTIFICATION

DCF-002-2F
6/25 (Rev)

Section I: Demographic				
Child Last, First Name:		DOB:	Gender: Select One...	Race: Select One
Medical Diagnosis:				
Behavioral Health Diagnosis:				
Placement Date:			# of Placements:	
Link ID:	Person Id:	DCF Region/Area Office: Select One....		
Caregiver Last, First Name:		Type of caregiver: Select One...		Link Provider ID:

Section II: Stabilization Level

Level 1: Mild

- Diagnosis managed by therapy appointments or specialty care treatment appointments occurring at least twice per week that cannot otherwise be supported by FFT-FC.
- Requires a caregiver to participate in recommended treatment and training specific to the child need.

Level 2: Moderate

- Intensity of support is dependent on the child's needs, including but not limited to a combination of supports requiring multiple appointment or in home service several times per week, involved with juvenile justice system, substance use treatment, experiencing dysregulating behaviors and medical complex.
- Frequent supervision and support required by a caregiver who is in the process of being trained or trained for the specific needs of the child.
- In home personal care support and treatment required.
- Able to safely reside in home setting with intensive/ongoing supports occurring at least most days of the week.
- May require periodic, short-term treatment out of the home setting to support stability (i.e. inpatient treatment at community hospital, 911/ 211 /UCC/SAC supports needed, etc.)

Level 3: Severe

- 24-hour supervision due to safety concerns and risk (i.e. frequent aggressive incidents towards others, significant substance use causing severe impairment). The supervision plan will be tailored to the child's needs.
- Approved for treatment setting outside of the home including and not limited to Therapeutic Group Home, Residential Treatment Center, Psychiatric Residential Treatment Facilities, and Albert J. Solnit Children Center-South Hospital etc.
- Consideration of those needing extensive supports but cannot access treatment settings.

Level of recommendation: Select One...

Justification:

Section III: Approval			
REQUIRED SIGNATURES (*as applicable*):			
Position	**Signature**	**Notes**	**Date**
Office Director			
FCD Program Director			
Behavioral Health Clinical Manager			
Statewide Director of Foster Care			
Health Management Administrator			
Assistant Chief			
Bureau Chief of Child Welfare			
Chief Fiscal Officer or designee			
Comments:			
Approved ☐		**Denied** ☐	**Decision Date:**
If approved, Redetermination Date:			