Member's Full Name: Medicaid #:

SERVICE AUTHORIZATION FORM

PSYCHOSOCIAL REHABILITATION (PSR) H2017 INITIAL
Service Authorization Request Form

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name:		Organization Name:	
Member Last Name:		Group NPI #:	
Medicaid #:		Provider Tax ID #:	
Member Date of Birth:		Provider Phone:	
Gender:	☐ Male ☐ Female ☐ Other	Provider E-Mail:	
Member Plan ID #:		Provider Address:	
Member Address:		City, State, ZIP:	
City, State, ZIP:		Provider Fax:	
		Clinical Contact Name & Credentials*:	
		Clinical Contact Phone:	
		* *This is the individual to whom the MCO can reach out to answer additional clinical questions.*	

Request for Approval of Services: **Retro Review Request?** ☐ Yes ☐ No

From _____ (date), To _____ (date), for a total of _____ units of service.
Plan to provide _____ hours of service per week.

Is this a new service for the member? ☐ Yes ☐ No (If no, then complete an authorization for continuing care.)

Primary ICD-10 Diagnosis	
Secondary Diagnosis	

Name of Medication	Dosage	Frequency

If additional medications are prescribed, include listing of medications, dosage, and frequency in the Notes section.

SECTION I: PSYCHOSOCIAL REHABILITATION ELIGIBILITY CRITERIA	
Individuals qualifying for this service must demonstrate a clinical necessity for the service arising from mental, behavioral, or emotional illness that results in significant functional impairments in major life activities.	
Has difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of psychiatric hospitalization, homelessness, or isolation from social supports **Describe current symptoms and behaviors or other pertinent information which provides substantiation for CHECKED response (Identify frequency, intensity, and duration of each behavior):**	☐ Yes ☐ No

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Has difficulty in activities of daily living, such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized **Describe current symptoms and behaviors or other pertinent information which provides substantiation for CHECKED response (Identify frequency, intensity, and duration of each behavior):**	☐ Yes ☐ No
Exhibits such inappropriate behavior that documented, repeated interventions by the mental health, social services, or judicial system are or have been necessary. **Describe current symptoms and behaviors or other pertinent information which provides substantiation for CHECKED response (Identify frequency, intensity, and duration of each behavior):** **Below identify all current/past treatment providers, whether or not they are currently in treatment with provider, treatment goals and care coordination plan.**	☐ Yes ☐ No
Exhibits difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior ("Cognitive" does not refer to an individual with an intellectual or other developmental disability). **Describe current symptoms and behaviors or other pertinent information which provides substantiation for CHECKED response (Identify frequency, intensity, and duration of each behavior):**	☐ Yes ☐ No

Provider	Currently in Service?	Dates of Services/ Interventions	Outcomes/Current Progress
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		

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<table>
<tr><th colspan="2">Individual must meet <u>ONE</u> of the following; check applicable criteria:</th></tr>
<tr><td>Has experienced long-term or repeated psychiatric hospitalizations.
<table>
<tr><th>Name of Hospital</th><th>Dates of Hospitalization</th><th>Reason for Admission</th></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
<tr><td></td><td></td><td></td></tr>
</table></td><td>☐ Yes ☐ No</td></tr>
<tr><td>Experiences difficulty in activities of daily living and interpersonal skills.

Describe pertinent information which provides substantiation for CHECKED response (describe skill level and provide examples of skill deficits):</td><td>☐ Yes ☐ No</td></tr>
<tr><td>Has limited or non-existent support system.

Describe pertinent information which provides substantiation for CHECKED response:</td><td>☐ Yes ☐ No</td></tr>
<tr><td>Unable to function in the community without intensive intervention.

Describe current symptoms and behaviors or other pertinent information which provides substantiation for CHECKED response (Identify frequency, intensity, and duration of each behavior):</td><td>☐ Yes ☐ No</td></tr>
<tr><td>Requires long-term services to be maintained in the community.

Describe current symptoms and behaviors or other pertinent information which provides substantiation for CHECKED response (Identify frequency, intensity, and duration of each behavior):</td><td>☐ Yes ☐ No</td></tr>
</table>

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SECTION II: CARE COORDINATION

Primary Care Physician:

Other medical/behavioral health concerns (including substance abuse issues, personality disorders, dementia, cognitive impairments) that could impact services? ☐ Yes ☐ No (If yes, explain below.)

Please indicate other current medical/behavioral services and additional community supports and interventions being received:

Name of service/treatment	Provider/Contact Information	Frequency

Indicate plan to coordinate with primary care physician and other treatment providers/services to help ensure treatment interventions are coordinated:

SECTION III: TRAUMA-INFORMED CARE

Trauma-Informed Care (Many individuals have experienced potentially traumatic events in their lifetime. It is important that everyone is aware of the potential impact of trauma on those they serve, prepare to recognize and offer trauma-specific services when needed, and be mindful of trauma-informed interventions.)

Is there evidence to suggest this member has experienced trauma? ☐ Yes ☐ No

What is your plan to assess/refer and address the current and potential effects of that trauma?

SECTION IV: INDIVIDUAL TREATMENT GOALS

Treatment Goals/Progress:

- Describe person-centered, recovery-oriented, trauma-informed mental health treatment goals as they relate to requested treatment. Include individual strengths/barriers/gaps in service, and written in own words of individual seeking treatment/or in a manner that is understood by individual seeking treatment. If individual has identified a history of trauma, please include trauma-informed care interventions or referral in the treatment plan.
- Services are intended to include goal directed training/interventions that will enable individuals to learn the skills necessary to achieve or maintain stability in the least restrictive environment. Providers should demonstrate efforts to assist the individual in progressing toward goals to achieve their maximum potential.
- Please demonstrate that the individual is benefiting from the service as evidenced by objective progress toward goals or modifications and updates that are being made to the treatment plan to address areas with lack of progress.
- Include any appointments and medications adherence issues and plans to address this, if applicable.

Resources and Strengths: Document individual's strengths, preferences, extracurricular/community/social activities and people the individual identifies as supports.

Please describe any barriers to treatment:

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Goal/Objective (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):
How many days per week will be spent addressing this goal on average?
What specific training and interventions will be provided to address this goal?
How will you measure progress on the training or interventions provided?
Goal/Objective (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):
How many days per week will be spent addressing this goal on average?
What specific training and interventions will be provided to address this goal?
How will you measure progress on the counseling or interventions provided?
Goal/Objective (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):

How many days per week will be spent addressing this goal on average?
What specific training and interventions will be provided to address this goal?
How will you measure progress on the counseling or interventions provided?

SECTION V: DISCHARGE PLANNING		
DISCHARGE PLAN (Identify lower levels of care, natural supports, warm-hand off, care coordination needs)		
Step Down Service/Supports	Identified Provider/Supports	Plan to assist in transition
Recommended level of care at discharge:		
Estimated date of discharge:		

The appropriate assessment or addendum has been completed by an LMHP, LMHP-R, LMHP-S, or LMHP RP and the individual's psychiatric history information reviewed. By my signature (below) I am attesting that the individual meets the medical necessity criteria for the identified service. The assessment or applicable addendum for this service was completed on .

Signature (actual or electronic) of LMHP (Or R/S/RP):_____

Printed name of LMHP (Or R/S/RP):_____

Credentials: _____

Date: _____

If any additional CMHRS services were recommended by the assessment or addendum referenced above, please identify the services here:

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NOTES SECTION
If needed, use this page for any answer too long to fit within the form's provided spaces. Please note which section you are continuing before each answer.