CLEAR FORM

Member's Full Name: Medicaid #:

SERVICE AUTHORIZATION FORM

CMHRS CONTINUED STAY 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 NPI #	
Gender:	☐ Male ☐ Female ☐ Other	Provider Phone:	
Member Plan ID #:		Provider E-Mail:	
Member Address:		Provider Address:	
City, State, ZIP:		City, State, ZIP:	
Parent/Guardian:		Provider Fax:	
Parent/Guardian Contact Information:		Clinical Contact Name & Credentials*:	
Service Requested:	☐ IIH (H2012) ☐ MHSS (H0046) ☐ PSR (H2017) ☐ TDT (H2016)	Clinical Contact Phone:	
		* *This is the individual to whom the MCO can reach out to answer additional clinical questions.*	

If requesting TDT services, check one of the following: ☐ H2016 - (school day) ☐ H2016 – UG (after-school) ☐ H2016 – U7 (summer)
Provide the name of the school and/or setting where these services are being provided:
Initial Admission Date to Services:
Average # of units provided per week:
Request for approval of services: From _____ (date), To _____ (date), for a total of _____ units of service. Plan to provide _____ hours of service per week.

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.		

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SECTION I: CARE COORDINATION		
Please indicate other current medical/behavioral services and additional community interventions/supports received:		
Name of service/treatment	Provider/Contact Information	Frequency
Describe Care Coordination activities with other services and providers since the last authorization:		

SECTION II: TREATMENT PROGRESS
Treatment Goals/Progress: • Describe person-centered, recovery-oriented, trauma-informed mental health treatment goals as they relate to requested treatment. These should be written in the words of the individual or in a manner that is understood by the individual seeking treatment, include their individual strengths/barriers to/and gaps in service. If individual has identified a history of trauma, please include trauma-informed care interventions 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 medication adherence issues and plan 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:
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 interventions provided?
Progress toward Goal/Objective:
Lack of Progress and Changes made to ISP to address this:
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 interventions provided?
Progress toward Goal/Objective:
Lack of Progress and Changes made to ISP to address this:
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 interventions provided?
Progress toward Goal/Objective:
Lack of Progress and Changes made to ISP to address this:
For IIH and TDT **Overview of family involvement during service period with regards to the individual's ISP to include who has been involved and progress made/continuing needs of family goals/training:**
For MHSS members under 21 years of age **If member is not currently living in an independent living situation and has been actively transitioning into independent living at the initiation of services, please describe progress toward this transition within 6 months of receiving services:**

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SECTION III: 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
Estimated Date of Discharge:		
Recommended level of care at 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 date of the most recent 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.