

# Service Authorization Request

For out-of-county organizational providers only.

<b>Client's Name:</b>	<b>DOB:</b>	<b>Age:</b>	<b>CIN OR SSN:</b>
_____	_____	_____	_____
(First)	(Middle)	(Last)	
<b>Requesting Agency:</b>		<b>Contact Person:</b>	
_____		_____	
<b>Contact Phone Number:</b>		<b>Contact Fax Number:</b>	
_____		_____	
<b>Submitted to (MHP):</b>		<b>Date Submitted:</b>	
_____		_____	

- Initial Authorization for "Client Assessment" only.
  - Initial Authorization (Required documents: "Client Assessment" and "Client Plan")
  - Re-Authorization (Submit "Client Assessment Update" and "Client Plan" consistent with authorizing MHP's frequency requirements)
  - Annual Re-Authorization (Submit "Client Assessment Update" and "Client Plan" consistent with authorizing MHP's frequency requirements)
- (Please note: The MHP may request clarifying information / documentation to process your request for any of the above)

Speciality Mental Health Services Requested	Frequency of Service	Total Units Requested	Start Date	End Date	MHP Authorization (initial approved service)
<input type="checkbox"/> Day Treatment Intensive	_____ Days/week	3 Months			
	<input type="radio"/> Half Day <input type="radio"/> Full Day				
<input type="checkbox"/> Day Rehabilitation	_____ Days/week	6 Months			
	<input type="radio"/> Half Day <input type="radio"/> Full Day				

Explain why is this level of service necessary; if requesting more than 5 days per week, include your explanation for this level of care:

**Service Necessity:**

Child/youth requires a day rehabilitation, a structured program of rehabilitation and therapy, to:

1.  Improve personal independence and functioning.
2.  Maintain personal independence and functioning.
3.  Restore personal independence and functioning.

Child/youth requires day treatment intensive, a structured, multi-disciplinary program program of therapy, which may be:

1.  An alternative to hospitalization.
2.  To avoid placement in a more restrictive environment
3.  To maintain in a community setting.
4.  Other (list): \_\_\_\_\_

**Client Name:**

**Record/Identification Number:**

Specialty Mental Health Service(s) Requested	Frequency of Service(s) (Indicate how many AND select the Frequency)	Total Minutes Requested	Start Date	End Date	MHP Authorization (initial approved service)
<input type="checkbox"/> Assessment	_____ per <input type="radio"/> Week <input type="radio"/> Month <input type="radio"/> Authorization				
<input type="checkbox"/> Plan Development	_____ per <input type="radio"/> Week <input type="radio"/> Month <input type="radio"/> Authorization				
<input type="checkbox"/> Individual Therapy	_____ per <input type="radio"/> Week <input type="radio"/> Month <input type="radio"/> Authorization				
<input type="checkbox"/> Group Therapy	_____ per <input type="radio"/> Week <input type="radio"/> Month <input type="radio"/> Authorization				
<input type="checkbox"/> Collateral Services	_____ per <input type="radio"/> Week <input type="radio"/> Month <input type="radio"/> Authorization				
<input type="checkbox"/> Family Therapy	_____ per <input type="radio"/> Week <input type="radio"/> Month <input type="radio"/> Authorization				
<input type="checkbox"/> Targeted Case Mgmt	_____ per <input type="radio"/> Week <input type="radio"/> Month <input type="radio"/> Authorization				
<input type="checkbox"/> Medication Support	_____ per <input type="radio"/> Week <input type="radio"/> Month <input type="radio"/> Authorization				
<input type="checkbox"/> Other: _____	_____ per <input type="radio"/> Week <input type="radio"/> Month <input type="radio"/> Authorization				

Explain why this service level is necessary. If the above services are in addition to day treatment intensive/day rehabilitation services, explain why additional services are needed:

**Client Name:** \_\_\_\_\_

**Record/Identification Number:** \_\_\_\_\_

**Diagnosis**

List Primary Diagnosis first.

Axis I: P: _____ _____ _____ Axis II: P: _____ _____	Axis III: P: _____ _____ Axis IV: P: _____ _____ Axis V: Current GAF: _____	Past Year GAF (if available) _____
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**Impairment criteria** (Must have one of the following impairments as a result of the DSM diagnosis):

1.  A significant impairment in an important area of life functioning.
2.  A probability of significant deterioration in an important area of life functioning.
3.  A probability that the client will not progress developmentally as individually appropriate.
4.  For EPSDT beneficiaries, a condition as a result of a mental disorder that specialty mental health services can correct or ameliorate.

**Intervention criteria** (Must have 5, 6, and 7 or 7 and 8):

5.  The focus of treatment is to address the condition identified in the impairment criteria.
6.  The proposed intervention will significantly diminish the impairment or prevent significant deterioration in an important area of life functioning or allow the client to progress developmentally as individually appropriate.
7.  The condition would not be responsive to physical health care based treatment.
8.  For EPSDT beneficiaries, a condition as a result of a mental disorder that specialty mental health services can correct or ameliorate.

**Authorized by (Printed Name/License):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Authorizer's Phone Number:** \_\_\_\_\_