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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Complete all of the following: | | | | | | | | | | | | | | | | |
| 1. Date: | |  | | | | | | | | 5. Reporting Unit: | | |  | | |  |
| 2. Client Name: | | |  | | | | | | | 6. Clinician: | | |  | | |  |
| 3. Client InSyst #: | | | |  | | | | | | 7. Episode Opening Date: | | | |  | |  |
| 4. Provider Name: | | | | |  | | | | | 8. Authorization Cycle: | | | |  | |  |
|  | | | | | |  | | | |  | | | |  | |  |
| 9. Mental Health Services request for (check all that apply): | | | | | | | | | | | | | | | | |
| Individual Psychotherapy | | | | | | | Frequency |  | | | and As Needed | Duration | | |  |  |
| Individual Rehabilitation | | | | | | | Frequency |  | | | and As Needed | Duration | | |  |  |
| Medication Services | | | | | | | Frequency |  | | | and As Needed | Duration | | |  |  |
| Case Management/Brokerage | | | | | | | Frequency |  | | | and As Needed | Duration | | |  |  |
| Family Psychotherapy (with client present) | | | | | | | Frequency |  | | | and As Needed | Duration | | |  |  |
| Group Psychotherapy | | | | | | | Frequency |  | | | and As Needed | Duration | | |  |  |
| Collateral | | | | | | | Frequency |  | | | and As Needed | Duration | | |  |  |
| Collateral Family Group | | | | | | | Frequency |  | | | and As Needed | Duration | | |  |  |
| Multi-Family Group Psychotherapy (with client present) | | | | | | | Frequency |  | | | and As Needed | Duration | | |  |  |
| Group Rehabilitation | | | | | | | Frequency |  | | | and As Needed | Duration | | |  |  |
| Intensive Care Coordination | | | | | | | Frequency |  | | | and As Needed | Duration | | |  |  |
| Intensive Home Based Services | | | | | | | Frequency |  | | | and As Needed | Duration | | |  |  |
| TBS (Therapeutic Behavioral Services) | | | | | | | Frequency |  | | | and As Needed | Duration | | |  |  |
| Crisis Residential | | | | | | | Frequency |  | | | and As Needed | Duration | | |  |  |
| Adult Residential | | | | | | | Frequency |  | | | and As Needed | Duration | | |  |  |
|  | | | | | | |  |  | | |  |  | | |  |  |
| 10. Day Treatment Intensive: Duration  5 Days/Week or Less  Exceeds 5 Days/Week  Initial  Re-Authorization  Day Rehabilitation: Duration  5 Days/Week or Less  Exceeds 5 Days/Week  Initial  Re-Authorization  Other: County Authorization For DTI or DR  Yes  No Signature/License: | | | | | | | | | | | | | | | | |
| 11. Included Diagnosis and functional impairments – (Medi-Cal Included Diagnosis; and brief narrative that supports Primary Diagnosis – including impairments to functioning) | | | | | | | | | | | | | | | | |
| 12. Medical Necessity:  **Impairment Criteria (must have one of the following):** | | | | | | | | | **AND** | **Intervention Criteria (proposed INTERVENTION will….):** | | | | | | |
|  | Significant impairment in an important area of life function. | | | | | | | | **AND** | Significantly diminish impairment | | | | | | |
|  | Probability of significant deterioration in an important area of functioning. | | | | | | | | **AND** | Prevent significant deterioration in an important area of life functioning. | | | | | | |
|  | (Under 21) Without treatment will not progress developmentally as individually appropriate. | | | | | | | | **AND** | (Under 21) Probably allow the child to progress developmentally as individually appropriate. | | | | | | |
| 13. Agency Clinician: Recommend Approval:  Yes  No  Signature/Credentials  14. Agency Supervisor: Recommend Approval:  Yes  No  pending (30 Day Return)  Signature/Credentials | | | | | | | | | | | | | | | | |
| 15. CQRT Reviewer: Recommend Approval:  Yes  No  pending (30 Day Return)  Printed Name  Signature/Credentials (must be Licensed, registered or Waivered LPHA, or 2nd year Mental Health Trainee approved by licensed supervisor.) Date | | | | | | | | | | | | | | | | |
| 16. CQRT Chair:  Full Authorization – Start Date:       End Date:  By authorizing this case for Medi-Cal Specialty Mental health services, I attest that all requirements under Medi-Cal statutes have been met and that this chart is in compliance with Medi-Cal documentation standards.  Returns:  Authorization pending return in 30 Days –  No Authorization for specialty mental health services – Chart to be returned to CQRT:  CQRT Chair Comments:  CQRT Chair Signature/License: Date: | | | | | | | | | | | | | | | | |

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| --- | --- |
| **Use this Addendum if Chart is to be returned** | |
| **1st Return** | |
| Clinician Comments: | Supervisor Comments: |
| Agency Clinician: Recommend Approval:  Yes  No  Signature/Credentials  Agency Supervisor: Recommend Approval:  Yes  No  pending (30 Day Return)  Signature/Credentials | |
| CQRT Reviewer or Chair Comments: | |
| CQRT Reviewer: Recommend Approval:  Yes  No (30 Day Return)  pending (30 Day Return)  Signature/Credentials (must be Licensed, registered or Waivered LPHA, or 2nd year Mental Health Trainee approved by licensed supervisor.) | |
| CQRT Chair:  Full Authorization – Start Date:       End Date:  By authorizing this case for Medi-Cal Specialty Mental health services, I attest that all requirements under Medi-Cal statutes have been met and that this chart is in compliance with Medi-Cal documentation standards.  Returns:  30 Day Authorization – Chart to be returned to CQRT:  No Authorization – Chart to be returned to CQRT:  CQRT Chair Signature/Credentials: Date: | |
| **2nd Return** | |
| Clinician Comments: | Supervisor Comments: |
| Agency Clinician: Recommend Approval:  Yes  No  Signature/Credentials  Agency Supervisor: Recommend Approval:  Yes  No  pending (30 Day Return)  Signature/Credentials | |
| CQRT Reviewer or Chair Comments: | |
| CQRT Reviewer: Recommend Approval:  Yes  No (30 Day Return)  pending (30 Day Return)  Signature/Credentials (must be Licensed, registered or Waivered LPHA, or 2nd year Mental Health Trainee approved by licensed supervisor. ) | |
| CQRT Chair:  Full Authorization – Start Date:       End Date:  By authorizing this case for Medi-Cal Specialty Mental health services, I attest that all requirements under Medi-Cal statutes have been met and that this chart is in compliance with Medi-Cal documentation standards.  Returns:  30 Day Authorization – Chart to be returned to CQRT:  No Authorization – Chart to be returned to CQRT:  CQRT Chair Signature/Credentials: Date: | |