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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-AuthorizationDay 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/Credentials14. 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/CredentialsAgency 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/CredentialsAgency 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:       |