REQUEST FOR EXTENDED SERVICE (RES)

SUBMIT BEFORE FOURTH VISIT TO:
Authorization Services
Alameda County Behavioral Health Care Services
2000 Embarcadero Cove, Suite 400
Oakland, CA 94606
Phone (510) 567-8141 FAX (510) 567-8148

Client Name: ______ (press "Tab" on your keyboard)
Client DOB: ______
Client CIN or SSN: ______ (press "Tab" on your keyboard)
Provider Name: ______ ((press "Tab" on your keyboard)
Agency, if applicable: ______
Provider Phone: ______

General Instructions:

- This form is available online at www.acbhcs.org - BHCS Providers - Forms - Authorization, or http://www.acbhcs.org/providers/Forms/Forms.htm#Authorization.
- Please press "Tab" on your keyboard each time after typing in (1) Client Name, (2) Client CIN or SSN, and (3) Provider Name, in the box above. The same information will appear on other pages.
- To save a copy of the form onto your computer, after clicking on the RES or RCR link, select "Save" when "File Download" window appears.
- If client has a Client Information Number(CIN), the CIN must be used, per State regulations. (CIN is on Medi-Cal card and AEVS)
- Indicate "N/A" or "none" if the question is not relevant to client.
- Incomplete or illegible forms will be returned to sender.
- Remember to submit all five pages of the RES – your signature and client's signature are required on page 5.
- Submit extra pages, if needed, and check the following box to alert Authorization Services staff: ☐

RELATED TO YOUR REIMBURSEMENT

- Date of first face-to-face contact with client: ______
- If you have multiple sites, at which site does this client receive services? ______

1. CLIENT ASSESSMENT INFORMATION:

Current Presenting Problem: (as viewed by client and significant support persons, when applicable)

______

2. **Current Clinical Risks:** Identify risks to client and/or others, including situational risks and your management of those risks. (e.g., "DTS low risk; made safety plan, gave emergency contact & suicide hotline number.")

______

3. **Other Current Mental Health Providers:** (e.g., agency assistance, case manager, therapist, psychiatrist)

______

4. **Summary of Mental Health History** (e.g., danger to self/others, hospitalizations)

______

5. **Other Relevant History**: (e.g., social, work, education)

______

Client Name:__	Client CIN or SSN:__	Provider Name:

6. **Client < age 18: Complete Developmental History** (pre/perinatal events, physical/intellectual /psychosocial/academic):

☐ N/A (client 18+) ☐ In chart ☐ In progress; estimate complete by (date) _____
☐ Unable to obtain due to: _____

7. **Summary of Medical Conditions:** (If providing Medication Support, complete Box 7a below instead)
Physical health conditions (as relevant, including those in remission):

Current medications, as reported by client:

_____

Current psychiatric medications, dosage, and frequency (e.g., Seroquel 300 mg once daily at bedtime):

_____

Prescribed by MD/Agency: _____ Phone: _____

Comments (e.g., herbal remedies, suspected compliance issues): _____

PHYSICIAN TO COMPLETE

7a. **Complete this box if Medication Support is provided** (instead of #7 above).

Active medical conditions:

_____

Medication allergies/sensitivities: ***Note: <u>All</u> allergies must be prominently noted on front of chart or noted NKA***

_____

History of EPS? ☐No ☐Yes Current Assessment of EPS? ☐No ☐Yes

Past psychiatric medications (maximum dose, duration, when first prescribed, effectiveness, reason if discontinued):

_____

Current psychiatric medications (Dose, frequency, duration, target symptoms and response, side effects, and compliance):
(Note: Informed Consent must be in chart for all prescribed medication and when prescription is significantly changed.)

_____

Non-psychiatric medications (dose, duration, target medical condition):

_____

Comments:_____

Client Name: __	Client CIN or SSN: __	Provider Name:

8. **Summary of Substance Use History** (Complete for all clients):

	Current Use?		1st Use Date	Last Use Date
Alcohol	☐No	☐Yes	_____	_____
Tobacco	☐No	☐Yes	_____	_____
Caffeine	☐No	☐Yes	_____	_____
Prescriptions, not used as prescribed	☐No	☐Yes	_____	_____
Over-the-counter, not used per label	☐No	☐Yes	_____	_____
Other substance/drug use:				
_____	☐No	☐Yes	_____	_____
_____	☐No	☐Yes	_____	_____
_____	☐No	☐Yes	_____	_____
_____	☐No	☐Yes	_____	_____

Comments: _____

9. **Current Mental Status Exam** (WNL = Within Normal Limits):

Appearance/Behavior/Abnormal movements: ☐WNL ☐Other:_____

Speech: ☐WNL ☐Slow ☐Rapid ☐Monotonous ☐Loud ☐Pressured ☐Other:_____

Mood: ☐WNL ☐Depressed ☐Hypomanic/manic ☐Anxious ☐Angry ☐Irritable ☐Other:_____

Affect/Range: ☐WNL ☐Labile ☐Restricted ☐Blunted ☐Inappropriate ☐Other:_____

Thought Process: ☐WNL ☐Circumstantial ☐Tangential ☐Thought blocking ☐Flight of ideas ☐Racing thoughts ☐Incoherent ☐Other:_____

Thought Content: ☐WNL *(If not WNL, a description below is required.)*

Hallucinations (command?):_____

Delusions:_____

Suicidal ideas:_____

Homicidal ideas:_____

Other:_____

Orientation: ☐WNL ☐Other: _____

Concentration: ☐WNL ☐Other:_____

Memory: Immediate, Recent, & Remote ☐WNL ☐Other:_____

Intelligence: ☐WNL ☐Other:_____

Insight: ☐WNL ☐Other:_____ Judgment: ☐WNL ☐Other:_____

Impulse Control: ☐WNL ☐Other:_____

Attitude with interviewer & motivation for treatment: _____

If MSE is all WNL, please explain: _____

10. **Does the client have any special needs that must be addressed? (cultural, communication, physical limitations)**

_____

Client Name: __	Client CIN or SSN:__	Provider Name:

11. **Five-axis Diagnosis:** (per current DSM edition)

Axis I:		
Primary	_____	DSM code: _____
Secondary	_____	DSM code: _____
Tertiary	_____	DSM code: _____
Axis II:	_____	DSM code: _____
	_____	DSM code: _____
Axis III:	_____	Per _____ (e.g., client, MD, case mgr)
	_____	Per _____
	_____	Per _____

Axis IV Psychosocial & Environmental Concerns:

(Check all that apply. If Severe is checked, clinical risks must be addressed in Question #2.)

Key: Mild = functions normally with mild effort/support. Moderate = functions normally with moderate effort/support. Severe = functions normally only with substantial effort/support.

Problems with primary support group:	☐ Mild	☐ Moderate	☐ Severe
Problems related to the social environment:	☐ Mild	☐ Moderate	☐ Severe
Educational problems:	☐ Mild	☐ Moderate	☐ Severe
Occupational problems:	☐ Mild	☐ Moderate	☐ Severe
Housing problems:	☐ Mild	☐ Moderate	☐ Severe
Economic problems:	☐ Mild	☐ Moderate	☐ Severe
Problems with access to health care services:	☐ Mild	☐ Moderate	☐ Severe
Problems with activities of daily living (ADL's):	☐ Mild	☐ Moderate	☐ Severe
Problems related to interaction with legal system/crime:	☐ Mild	☐ Moderate	☐ Severe
Other psychosocial/environmental problems:	☐ Mild	☐ Moderate	☐ Severe

Axis V: ☐ Current __ ☐ Highest functioning in last 12 months __

12. **Medical Necessity for Services** (see ACBHCS Quality Assurance tab for more information)

Per clinician's current assessment, describe the medical necessity for mental health services. Indicate how client's current symptoms cause specific problems in daily functioning that the requested services will address.

_____

13. **Tentative Discharge Plan** (termination/transition plan):

_____

14. **Additional information, optional:**

_____

15. **If closing case,**

Reason for closing: _____

Date of last session: _____ **Referrals made:** _____

Client Name: __	Client CIN or SSN:__	Provider Name:

CLIENT PLAN

Complete in collaboration with client whenever possible.

1. Goals & Objectives

a. Client's goals (stated in client's own words, when possible):

______

b. Client's current strengths/skills/resources/supports that can be utilized to reach listed client's goals (e.g., client is motivated to reach goals, has family support, excellent knitting skills):

______

c. Six-month mental health objectives (observable or measurable) supporting improved mental health functioning (e.g., Client will attend knitting group two times a month for 3 months; client will report a score of 20 or below on the Beck Depression Inventory for 4 consecutive sessions; client will report improved concentration and decreased irritability by 50% by practicing stress reduction techniques at least 3 times a week):

______

2. Service Request for Authorization (Please use one line for each service. This is not required for HPAC.)

CPT Service Code (per your rate sheet)	**Service Description** (per your rate sheet)	**Frequency of Service**	**DSM Diagnostic Code(s) Addressed**
Example: X9502	Individual Therapy	1x/week	296.22

***CLIENT'S SIGNATURE:____ Date______________**

Legal Representative's signature., if required:________________________________ Date______________

Specify Legal Rep.'s Relationship (e.g., parent, guardian, conservator): ______________________________

If client/legal rep. verbally agreed with Client Plan but declined to sign, provide the Date: ________________

If client/legal rep. disagrees with Plan, provide Reason/Date: ____

<u>*Client's signature required above AND client must be offered copy of Client Plan page</u> unless clinician believes client's condition would suffer. If so, provide Reason/Date:____

Provider/Clinician information is required on the line below.

____

Clinician's printed name **Signature with discipline (e.g., MFT, LCSW, MD)** **Date**

If Clinician is not licensed, Licensed Supervisor's information is required on the line below:

____

Lic. Supervisor's printed name **Signature with discipline (e.g., MFT, LCSW, MD)** **Date**