SERVICE AUTHORIZATION REQUEST

For out-of-county organizational providers only.

Client's Name:	**DOB/Age:**	**CIN or SSN:**
Requesting Agency:	**Contact Person:**	
Contact Phone Number:	**Contact Fax Number:**	
Submitted to (MHP):	**Date Submitted:**	

- ☐ **Initial Authorization for "Client Assessment" only.**
- ☐ **Initial Authorization (Required documents: "Client Assessment" and "Client Plan")**
- ☐ **Re-Authorization (Submit "Client Assessment" and "Client Plan" consistent with authorizing MHP's frequency requirements)**
- ☐ **Annual Re-Authorization (Submit "Client Assessment" 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.

Specialty Mental Health Service Requested	**Frequency of Service**	**Total Units Requested**	**Start Date**	**End Date**	**MHP Authorization (initial approved service)**
☐ Day Treatment Intensive	_____ Days/week ☐ Half Day ☐ Full Day	3 months			
☐ Day Rehabilitation	_____ Days/week ☐ Half Day ☐ Full Day	6 months			

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 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 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 circle the frequency)	Total Minutes Requested	Start Date	End Date	MHP Authorization (initial approved service)
☐ Assessment	Week Month _____ per authorization				
☐ Plan Development	Week Month _____ per authorization				
☐ Individual Therapy	Week Month _____ per authorization				
☐ Group Therapy	Week Month _____ per authorization				
☐ Family Therapy	Week Month _____ per authorization				
☐ Collateral Services	Week Month _____ per authorization				
☐ Targeted Case Mgmt	Week Month _____ per authorization				
☐ Medication Support	Week Month _____ per authorization				
☐ Other: _____	Week Month _____ per 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:

_____

_____

_____

_____

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) _____

Client Name: **Record/Identification Number:**

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:**_____