DAY TREATMENT AUTHORIZATION CRITERIA
FOR
ALAMEDA COUNTY PROGRAMS

1. Name of Youth _____D.O.B._____
2. Placement Worker's Name & Phone Number _____
3. Date of Project Destiny eligibility (if applicable) _____
4. Presenting Problems/reason for admission _____
   _____
   _____

5a. Axis I Diagnosis_____Date_____
5b. Name & License Type of person providing diagnosis
_____

6. Medical Necessity Criteria (see chart below) for Impairment, Intervention Criteria and Service Necessity

MEDICAL NECESSITY	YES	NO
Impairment Criteria : Must have one of the following as a result of DX:		
1. A significant impairment in an important area of life functioning , or		
2. A probability of significant deterioration in an important area of life functioning, or		
3. A probability that the child will not progress developmentally as Individually appropriate.		
3A. Children covered under EPSDT qualify if they have a mental disorder, which can be corrected or ameliorated. (Current DHS EPSDT regulations apply).		
Intervention Criteria: Must have all 1,2, and 3		
1.The focus of treatment is to address the condition identified in the Impairment Criteria, and		
2. It is expected the client will benefit from treatment by diminishing the impairment or preventing significant deterioration in an important area of life functioning, or		
2A. It is probable the child will progress developmentally as individually appropriate, or		
2B. If covered by EPSDT can the condition be corrected or ameliorated through specialty mental health services?		
3. The condition would not be responsive to physical health care based treatment.		
Service Necessity:		
1. What is the risk of the client's level of dysfunction increasing if fewer services were provided? Low 1 2 3 4 5 High		
2. Can a different type/level of **Specialty Mental Health Services** meet this client's need for services reasonably well?		
3. Can a primary care physician or private practitioner/therapist meet this client's need for services (a lower level of care) reasonably well?		
Comments: **Signature of LPHA Completing form** _____**Date** _____ **Phone Number**_____		