Behavioral Health Department
Alameda County Health

2000 EMBARCADERO COVE, SUITE 110
OAKLAND, CA 94606
510-567-8141 FAX: 888-860-8068
Utilization Management

Level of Care Determination Tool for Residential Services

Client's Name _____ **Client's Date of Birth** _____

Diagnosis (if known at time of screening) _____

Purpose and Instructions: This form should be used when requesting authorization for adult residential and crisis residential services. It contains the admission criteria for these levels of care. Please complete the section that applies to your facility type as well as the Pertinent Current and Past Information section at the bottom of the form. Send your completed form to the ACBH staff member who completes your initial authorizations along with the Service Authorization Request (SAR) and referral form.

ADULT RESIDENTIAL TREATMENT ADMISSION CRITERIA
Please screen for the following and check each box as appropriate
☐ The beneficiary has one or both of the following: Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities and/ or a reasonable probability of significant deterioration in an important area of life functioning please describe below). ☐ The beneficiary's condition as described in paragraph (1) is due to either of the following: a diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems and/or a suspected mental health disorder that has not yet been diagnosed. ☐ Beneficiary is not sufficiently stable to be treated outside of a highly structured 24-hour therapeutic setting, but does not require a crisis or emergency higher level of care. ☐ Beneficiary's behavior or symptoms, as evidenced by initial screening and/or assessment are likely to respond to treatment. ☐ Beneficiary has sufficient cognitive capacity to respond to active, intensive and time-limited behavioral health treatment and intervention. ☐ Beneficiary has only poor-to-fair community supports sufficient to maintain him/her within the community with treatment at a lower level of care. ☐ Beneficiary requires a time-limited period for stabilization and lower-level-of care and community resource connection for successful community reintegration. ☐ Beneficiary does not have medical complications that can only be treated at a medical/surgical setting or requires nursing care. ☐ Beneficiary (or guardian as appropriate) is willing to participate in treatment voluntarily.

Reference: Behavioral Health Information Notice (BHIN) No: 21-073

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

2000 Embarcadero Cove, Suite 400
Oakland, Ca 94606
510-567-8100 / TTY 510-533-5018
Karyn L. Tribble, PsyD, LCSW, Director

CRISIS RESIDENTIAL TREATMENT ADMISSION CRITERIA

Please screen for the following and check each box as appropriate

☐ Beneficiary has one or both of the following: Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities and/or a reasonable probability of significant deterioration in an important area of life functioning (please escribe below).

☐ Beneficiary's condition as described in paragraph (1) is due to either of the following: a diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems and/or a suspected mental disorder that has not yet been diagnosed

☐ Beneficiary is experiencing an acute psychiatric episode or crisis and:

a) Requires a 24-hour structured setting and if not admitted will likely require acute psychiatric hospitalization.

b) It is expected that the proposed interventions will significantly diminish the impairment or prevent significant deterioration in an important area of life functioning.

c) Does not present with imminent risk to self or others requiring a higher level of care (i.e. acute psychiatric hospitalization).

d) Cannot be safely treated in a less restrictive setting.

☐ Beneficiary does not have medical complications that can only be treated at a medical/surgical setting or requires nursing care.

☐ Beneficiary (or guardian as appropriate) is willing to participate in treatment voluntarily.

Pertinent Current/Past Information ***(please specify current functional impairments in a core area of life due to the condition(s) being treated):***

Current symptoms and functional impairments: _____

_____

_____

Brief relevant history: _____

_____

_____

Clinician Name: _____ Clinician Title: _____

Clinician Signature: _____ Screening Date: _____

Reference: Behavioral Health Information Notice (BHIN) No: 21-073