Client Name:       (press “Tab” on your keyboard)

**REQUEST FOR CONTINUED SERVICE (RCS)**

SUBMIT 2 WEEKS PRIOR TO CURRENT AUTHORIZATION EXPIRATION DATE TO:

Utilization Management Program (UM)

Alameda County Behavioral Health Care Services

2000 Embarcadero Cove, Suite 400

Oakland, CA 94606

Phone (510) 567-8141 FAX (888) 860-8068

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 <http://www.acbhcs.org/providers/Forms/Forms.htm> under “Utilization Management” section.
* 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.
* If client has a Client Identification Number (CIN), the CIN must be used, per State regulations. (CIN is on the 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.
* Please note: Only one age-appropriate screening form is required. Your signature is required on page 6.
* Submit extra pages, if needed, and check the following box to alert UM 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?**

**CLIENT ASSESSMENT INFORMATION:**

1. **Please describe your client’s current presenting problems. Include specific risks, symptoms, and diagnosis (es), and the specific, current impairment(s) in daily functioning that result. What are the specific maladaptive behaviors in important areas of daily functioning that result from your client’s mental illness? (**e.g. suicidal ideation, poor sleep, poor eating, low energy and social isolation due to a major depressive episode puts the client at risk for self-harm and loss of housing, and prevents ability to work and hinders ability to find community support)
2. **If not already noted above, please indicate current medical necessity for continuing Specialty Mental Health treatment?**

Client Name: Client CIN or SSN: Provider Name:

1. **Criteria Screening:** (Please choose age appropriate screening form):

 **Adult 18+**

|  |  |  |
| --- | --- | --- |
| **List A (Check all that currently apply)** | **List B (Check all that currently apply)** | **List C** |
| **[ ]** Persistent mental health symptoms & impairments after psychiatric consult and 2 or more medication trials in past 6 months [ ]  Co-morbid mental health and serious health conditions-  Specify:      [ ]  Behavior problems (aggressive/assaultive/self-destructive/extreme isolation)- Specify:      [ ]  3+ ED visits or 911 calls in past year[ ]  Significant current life stressors [e.g. homelessness, domestic violence, recent loss]-  Specify:      [ ]  Hx of trauma/PTSD that is impacting current functioning[ ]  Non-minor dependent [ ]  May not progress developmentally as individually appropriate without mental health intervention (ages 18 to 21only) | [ ]  2+ in-patient psychiatric hospitalizations within past 18 months[ ]  Functionally significant paranoia, delusions, hallucinations[ ]  Current & on-going suicidal/significant self-injurious/homicidal preoccupation or behavior in past year-  Specify:     [ ]  Transitional Age Youth with acute psychotic episode[ ]  Eating disorder with related medical complications[ ]  Personality disorder with significant functional impairment [ ]  Significant functional impairment (not listed above) due to a mental health condition | [ ]  Drug or alcohol addiction and failed SBI (screening & brief intervention at primary care) |

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| **Meets Criteria For:** |
| **Primary Care Provider** (**PCP) care**  | [ ] 1-2 in List A and none in List B |
| **Managed Care Plan (MCP)** [Alameda Alliance, Anthem Blue Cross or Kaiser] | [ ] 3 in list A (2 if ages 18-21) and none in list B OR[ ] Diagnosis excluded from county MHP  |
| **Specialty Mental Health Plan**  | [ ]  4 or more in list A (3 or more if ages 18-21) OR[ ] 1 or more in list B |
| Refer to County Alcohol & Drug Program (1-800-491-9099) | [ ] 1 from list C |

**PLEASE LIST COVERED DIAGNOSES, INCLUDING ICD-10 CODES,**

**AND, FOR ANY OF THE CHECKED ITEMS IN LISTS A & B ABOVE, YOU MUST PROVIDE CLARIFYING DETAILS IF NOT ALREADY SPECIFIED ELSEWHERE IN THIS DOCUMENT:**

Client Name: Client CIN or SSN: Provider Name:

**Child 6-17**

|  |  |  |
| --- | --- | --- |
| **List A (Check all that currently apply)**  | **List B (Check all that currently apply)** | **List C**  |
| [ ]  Impulsivity/hyperactivity [ ]  Trauma/recent loss [ ]  Withdrawn/Isolative [ ]  Mild-moderate depression/anxiety [ ]  Behavior problems (aggressive/self-destructive/assaultive/bullying/oppositional) [ ]  Significant family stressors \* [ ]  CPS report in the last 6 months [ ]  Excessive truancy or failing school [ ]  Difficulty developing and sustaining peer relationships [ ]  Eating disorder without medical complications [ ]  Court dependent or ward of court [ ]  May not progress developmentally as individually appropriate without mental health intervention  | [ ]  1 or more psychiatric hospitalization(s) in past year [ ]  Suicidal/homicidal preoccupations or behaviors in past year [ ]  Self-injurious behaviors [ ]  Paranoia, delusions, hallucinations [ ]  Currently in out-of-home foster care placement [ ]  Juvenile probation supervision with current placement order [ ]  Functionally significant depression/anxiety\*\* [ ]  Eating disorder with medical complications [ ]  At risk of losing home or school placement due to mental health issues  | [ ]  Substance abuse |

\* Significant family stressors: Caretaker(s) with serious physical, mental health, substance use disorders, or developmental disabilities, domestic violence, unstable housing or homelessness.

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| --- |
| **Referral Algorithm** |
| 1**.**  |  Remains in **PCP care** with Beacon consult or therapy only | [ ] 1- in List A and none in List B |
| 2.  |  **Managed Care Plan (MCP)** [Alameda Alliance, Anthem Blue Cross or Kaiser] | [ ] 2 in list A and none in list B OR[ ] Diagnosis excluded from county MHP  |
| 3. |  Refer to **County Mental Health Plan** for assessment | [ ]  3 or more in list A OR[ ] 1 or more in list B |
| 4.  |  Refer to **County program** or community resources | [ ] 1 in list C |

**PLEASE LIST COVERED DIAGNOSES, INCLUDING ICD-10 CODES,**

**AND, FOR ANY OF THE CHECKED ITEMS IN LISTS A & B ABOVE, YOU MUST PROVIDE CLARIFYING DETAILS IF NOT ALREADY SPECIFIED ELSEWHERE IN THIS DOCUMENT:**

Client Name: Client CIN or SSN: Provider Name:

**Child 0-5**

|  |  |
| --- | --- |
| **List A (Check all that apply)** | **List B (Check all that apply)** |
| [ ]  Impulsivity/hyperactivity [ ]  Withdrawn/Isolative [ ]  Mild-moderate depression/anxiety [ ]  Excessive crying; difficult to soothe [ ]  Significant family stressors \* [ ]  CPS report in the last 6 months [ ]  Limited receptive and expressive communication skills [ ]  Sleep Concerns: difficulty falling asleep, night waking, nightmares [ ]  Peer relationship issues - little enjoyment or interest in peers; self-isolating; frequent conflict with peers [ ]  Feeding/elimination difficulties [ ]  Learning Difficulties [ ]  Sexualized Behaviors [ ]  Serious medical issues/other disabilities [ ]  May not progress developmentally as individually appropriate without mental health intervention  | [ ]  Significant Parent/Child attachment concerns Child age 0-3 with at least 2 items from List A [ ]  Aggression and/or frequent tantrums [ ]  Neglect/Abuse [ ]  Self-Harm: frequent head banging/risky behavior Trauma [ ]  Currently in out-of-home foster care placement [ ]  At risk of losing home, child care or preschool placement due to mental health issue [ ]  Separation from/loss of primary caregiver  |

\* Significant family stressors: Caretaker(s) with serious physical, mental health, substance use disorders, or developmental disabilities, domestic violence, unstable housing or homelessness.

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| --- |
| **Referral Algorithm** |
| 1**.**  |  Remains in **PCP care** with Beacon consult or therapy only | [ ] 1- in List A and none in List B |
| 2.  |  **Managed Care Plan (MCP)** [Alameda Alliance, Anthem Blue Cross or Kaiser]) | [ ] 2 in list A and none in list B OR[ ] Diagnosis excluded from county MHP  |
| 3. |  Refer to **County Mental Health Plan** for assessment | [ ]  3 or more in list A OR[ ] 1 or more in list B |

**PLEASE LIST COVERED DIAGNOSES, INCLUDING ICD-10 CODES**

**AND, FOR ANY OF THE CHECKED ITEMS IN LISTS A & B ABOVE, YOU MUST PROVIDE CLARIFYING DETAILS IF NOT ALREADY SPECIFIED ELSEWHERE IN THIS DOCUMENT:**

Client Name: Client CIN or SSN: Provider Name:

1. **For recent psychiatric hospitalizations or crisis visits, please Indicate reason, dates, and duration:**
2. **List the current treatment goals (Achievable within 6 months):**

1. **What previous treatment goals have been met?**
2. **Current Substance Abuse Issues:**
3. **Is psychotropic medication being prescribed? [ ] Yes [ ] No**

 **If yes, please list current medications including dosage and frequency (e.g. Seroquel 300mg once daily at bedtime):**

* **Is a medication evaluation indicated? [ ] Yes [ ] No**
1. **Has the client been seen by a Primary Care Clinic/Physician since treatment began?** **[ ] Yes [ ] No**

**If so, for what health problems?**

**Name of Physician/Clinic:**

**Have you consulted with the Primary Care Clinic/Physician?** **[ ] Yes [ ] No**

|  |
| --- |
| **PSYCHIATRIST TO COMPLETE**1. Active medical conditions:
2. Medication allergies/sensitivities

 History of Serious Side Effects? [ ] Yes [ ] No Current Assessment of Serious Side Effects? [ ] Yes [ ] No1. Past psychiatric medications (maximum dose, duration, when first prescribed, effectiveness, reason if discontinued):

     1. 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.)*
2. Non-psychiatric medications (dose, duration, target medical condition):
3. Comments:
 |
|  |
|  |

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

Client Name: Client CIN or SSN: Provider Name:

1. **What are the current barriers to discharge from Specialty Mental Health Services to a lower level of care** (i.e. Managed Care Plan: Alameda Alliance/Beacon, Anthem Blue Cross or Kaiser; PCP)
2. **Discharge Plan** (termination/transition plan):
3. **Additional information, optional:**
4. **Service Request for Authorization**:

**IF THE FULL PACKAGE OF SERVICES IS REQUIRED for treatment completion, please check here:** [ ]

**OR**

 **IF LESS THAN THE FULL PACKAGE OF SERVICES IS REQUIRED, please check here:** [ ]  **and specify required services below:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **CPT Service Code**(per your rate sheet) | **Service Description**(per your rate sheet) | **Number of Service Required** | **Frequency of Service** | **ICD-10 Diagnostic Code(s)****Addressed** |
| Example: 90834 | Individual Therapy | 4 | 1x/month | F33.2 |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |

***(PLEASE NOTE: An annual assessment & a client plan every 6 months are required before service delivery.)***

**If this is an open Social Services, Children and Family Services (CFS) case, check here [ ]**

**If CFS case has been closed, indicate the closure date:**      **.**

**If applicable, indicate current Child Welfare Worker (CWW) contact information:**

Name Phone#

1. **IF CLOSING CASE: Reason for closing:**

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

***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**

[ ]  **Check here if you’ve received minor consent for treatment under Family Code 6924 *and*** the **authorization letter**

 **is not to be sent your client’s parent or guardian.**