Service Authorization Request

For out-of-county organizational providers only.

Client's Name:			DOB:	Age:	CIN OR SSN:
(First)	(Middle)	(Last)			

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 Update" and "Client Plan" consistent with authorizing MHP's frequency requirements)
- ◯ Annual Re-Authorization (Submit "Client Assessment Update" 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)

Speciality Mental Health Services 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 a 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 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 select the Frequency)	Total Minutes Requested	Start Date	End Date	MHP Authorization (initial approved service)
☐ Assessment	____ per ○ Week ○ Month ○ Authorization				
☐ Plan Development	____ per ○ Week ○ Month ○ Authorization				
☐ Individual Therapy	____ per ○ Week ○ Month ○ Authorization				
☐ Group Therapy	____ per ○ Week ○ Month ○ Authorization				
☐ Collateral Services	____ per ○ Week ○ Month ○ Authorization				
☐ Family Therapy	____ per ○ Week ○ Month ○ Authorization				
☐ Targeted Case Mgmt	____ per ○ Week ○ Month ○ Authorization				
☐ Medication Support	____ per ○ Week ○ Month ○ Authorization				
☐ Other: _____	____ per ○ Week ○ Month ○ 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:

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

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) _____

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:** _____