PROJECT BRAVO
BEHAVIORAL HEALTH REDESIGN FOR ACCESS, VALUE & OUTCOMES

CLEAR FORM

VIRGINIA'S MEDICAID PROGRAM DMAS

THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Community Stabilization (S9482)

CONTINUED STAY Service Authorization Request Form

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name:		Organization Name:	
Member Last Name:		Group NPI #:	
Medicaid #:		Provider Tax ID #:	
Member Date of Birth:		Provider Phone:	
Gender:		Provider E-Mail:	
Member Plan ID #:		Provider Address:	
Member Street Address:		City, State, ZIP:	
City, State, ZIP:		Provider Fax:	
Member Phone #:		**Clinical Contact** Name and Credentials*:	
Parent/Legal Guardian Name (s):		Phone #	
Parent/Legal Guardian Phone #:		* *The individual to whom the MCO can reach out to in order to gather additional necessary clinical information.*	

Request for Approval of Services			
Retro Review Request? **Yes** **No**		**Data Platform Reference #**	
If the member is currently participating in this service, start date of service:			
Proposed/Requested Service Information: From _____ (date), To _____ (date), for a total of _____ units of service. Plan to provide _____ hours of service per week.			
Primary ICD-10 Diagnosis			
Secondary Diagnosis(es)			

Medication Update			
Name of Medication	Dose	Frequency	For any changes, note if: New, Ended or Changed in dose/frequency from last authorization

Member Full Name: Medicaid #:

SECTION I: CARE COORDINATION

Please list all medical/behavioral services or community interventions/supports the individual has participated in since the last authorization, as well as any changes:

Name of Service/Support	Provider Contact Info	Frequency	*For any changes, note if:* New, Ended or Changed in frequency/intensity from last authorization

Section II: TREATMENT PROGRESS

Along with this document, please include the following with your submission:

1. An assessment meeting one of the following:
   a. Comprehensive Needs Assessment (CNA), **or**
   b. Prescreening completed within 72-Hours of admission **or**
   c. A DBHDS approved assessment for crisis services can be used to meet this requirement if conducted by a LMHP, LMHP-R, LMHP-RP, or LMHP-S; **and**

2. A current addendum to the above assessment, (can be in a progress note) that briefly describes any new information impacting care, progress and interventions to date, and a description of the rationale for continued service delivery, and evidence the individual meets medical necessity criteria **and**

3. Current Safety Plan

Section III: RECOVERY and DISCHARGE PLANNING

1. A clinically appropriate and specific behavioral health service provider referral(s) has been identified and a plan for the timeline of transition from Community Stabilization to that provider has been established and documented. *Provide updated details about the transition plan: specific dates and times for the assessment or start of service, any details about transition sessions, barriers to the transition and attempted solutions to those barriers.*

2. If the timeline for this transition (#iii,b) exceeds 2 weeks, the Community Stabilization provider has documented communications with additional, specific service providers to support additional service options or potentially faster access to the recommended service type. *Please provide **updated** additional referral information, service type/ procedure code, provider and contact information (if applicable) since the last service authorization.*

3. What types of outreach, additional formal services or natural supports, or resources will be necessary to transition the individual to a service (s) that will meet the individual's needs?

4. Has the provider contacted the health plan and engaged in care coordination to assist the individual, if so, who was contacted, when and what was the outcome?

What is the best estimate of the discharge date for this individual?

By my signature (below), I am attesting that 1) an LMHP, LMHP-R, LMHP-S or LMHP-RP has reviewed the individual's psychiatric history and completed the appropriate assessment or addendum; and 2) that this assessment indicates that the individual meets the medical necessity criteria for the identified service. The assessment or applicable addendum for this service was completed on the following date(s): _____

Signature (actual or electronic) of LMHP (Or R/S/RP): _____

Printed Name of LMHP (Or R/S/RP): _____

Credentials: _____

Date: _____

Notes Section