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)
INITIAL Service Authorization Request Form

Please be mindful of notes throughout this form providing reference to where documentation obtained during the Comprehensive Needs Assessment (CNA) are relevant and can be used for efficiency.

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.

Identify all known treatment periods of Community Stabilization and other behavioral health services that have been provided by any providers including the requesting provider in the past 30 calendar days:

Provider	Dates of Service/Intervention	Outcomes

Primary ICD-10 Diagnosis	
Secondary Diagnosis(es)	

Other medical/behavioral health concerns (including substance use issues, personality disorders, dementia, cognitive impairments) that could impact services? Yes No (If yes, explain below.)

SECTION I: ADMISSION CRITERIA

Individuals must meet ALL of the following criteria; note that some criteria have multiple sub-criteria for consideration.

1. Specify the DSM diagnosis or provisional diagnosis corresponding with the ICD-10 diagnosis(es).

Describe the individual's current symptoms (including frequency, intensity and duration) and areas of functional impairment. Corresponding CNA Elements: 1, 6, 7, 12

2. The individual has demonstrated a level of acuity indicating that they are at risk for crisis-cycling or dangerous decompensation in functioning and additional support in the form of Community Stabilization is required to prevent an acute inpatient admission. *Is the individual able to sustain safety during the interim period between services, if not, why? Describe any repeated occurrences of behaviors that are endangering to self or others, are difficult to control, cause distress, or other evidence that the individual is at risk of crisis-cycling or dangerous decompensation and an acute inpatient admission.*

3. Prior to admission the individual must meet **either a. or b. below**:

a. The individual is residing in a Therapeutic Group Home (TGH) or ASAM 3.1. *Please provide TGH provider name, address and clinical contact information.*

Yes

No

Provider Name: _____

Provider Address: _____

Clinical Contact Name: _____

Clinical Contact Phone: _____ Clinical Contact Email: _____

Notes: _____

If yes, skip to Section II: Other Required Information

b. The individual needs Community Stabilization as a transition service. **Must meet criteria i or ii:**

i. A Licensed Mental Health Professional (LMHP), LMHP-R, LMHP-RP or LMHP-S at a Community Services Board (CSB) same day access intake, a Managed Care Organization, or Fee-For-Service contractor determines Community Stabilization is needed to support a transition in care and link an individual to appropriate services. *Please provide provider name, address, clinical contact information for the identified LMHP.*

Yes

No

Provider Name: _____

Provider Address: _____

LMHP Contact Name: _____

LMHP Contact Phone: _____ LMHP Contact Email: _____

Notes: _____

ii. The individual is being discharged from one of the below services:

Yes

_____

No

Please provide provider/agency name, address, clinical contact information for the identified professional coordinating the discharge plan.

Provider Name: _____

Provider Address: _____

Contact Name: _____

Contact Phone: _____ Contact Email: _____

Notes: _____

iii. Individuals meeting either criteria i. or criteria ii. above must also meet the following additional criteria:

a. The service that the individual needs and is recommended by a professional listed in item i. above or a professional coordinating the discharge plan from services listed in item ii. above is not currently available for immediate access. *What is the intended service (name and procedure code) and what are the barriers to immediate availability?*

Yes

No

Name and Procedure Code of identified Behavioral Health service: _____

b. 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 details about the transition plan: specific dates and times for the assessment or start of service, and any details about transition sessions.*

Yes

No

Provider Name/Agency: _____

Provider Address: _____

Contact Name: _____

Contact Phone: _____ Contact Email: _____

Notes: _____

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 additional referral information, service type/ procedure code, provider and contact information (if applicable).*

Member Full Name: Medicaid #:

Section II: OTHER REQUIRED INFORMATION

Along with this document, please include the following with your submission (if applicable):

If criteria (#3,b,i) is met submit the following:

1. Documented referral from the Community Services Board (CSB) same day access intake, a Managed Care Organization, or Fee-For-Service contractor. The referral must include the name of both the referring provider and the Community Stabilization provider.

If criteria (#3,b,ii) is met, submit the following:

2. Documented referral from discharging provider/agency. The referral must include the name of both the referring provider/agency and the Community Stabilization provider.

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: _____

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

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

Credentials: _____ NPI #: _____

Date: _____

Notes