Member's Full Name: Medicaid #:

SERVICE AUTHORIZATION FORM

INTENSIVE IN-HOME (IIH) H2012 INITIAL
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:	☐ Male ☐ Female ☐ Other	Provider E-Mail:	
Member Plan ID #:		Provider Address:	
Member Address:		City, State, ZIP:	
City, State, ZIP:		Provider Fax:	
Parent/Guardian:		Clinical Contact Name & Credentials*:	
Parent/Guardian Contact Information:		Clinical Contact Phone:	
		* *This is the individual to whom the MCO can reach out to answer additional clinical questions.*	

Request for Approval of Services: **Retro Review Request?** ☐ Yes ☐ No

From _____ (date), To _____ (date), for a total of _____ units of service.
Plan to provide _____ hours of service per week.

Is this a new service for the member? ☐ Yes ☐ No (If no, then complete an authorization for continuing care.)

Primary ICD-10 Diagnosis	
Secondary Diagnosis	

Name of Medication	Dosage	Frequency

If additional medications are prescribed, include listing of medications, dosage, and frequency in the Notes section.

SECTION I: INTENSIVE IN HOME ELIGIBILITY CRITERIA	
Individuals shall demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness resulting in significant functional impairments in major life activities.	
There is a parent/legal guardian or responsible adult with whom the member is living who is willing to participate in services with the goal of keeping the child with the family.	☐ Yes ☐ No
The diagnosis must support the mental, behavioral or emotional illness attributed to the recent significant functional impairments in major life activities	☐ Yes ☐ No

Member's Full Name: Medicaid #:

Individual must meet TWO of the following on a continuing or intermittent basis; check applicable criteria:

Has difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out of home placement because of conflicts with family or community (Note: Please refer to DMAS provider manual for risk of hospitalization and out of home placement definitions/criteria).

☐ Yes ☐ No

*** *If a child is at risk of hospitalization or an out of home placement, state the specific reason and what the out-of-home placement may be.***

Describe current symptoms and behaviors or other pertinent information which provides substantiation for CHECKED response (Identify frequency, intensity, and duration of each behavior):

Exhibits such inappropriate behavior that documented, repeated interventions by the mental health, social services or judicial system are or have been necessary resulting in being at risk for out of home placement.

☐ Yes ☐ No

Describe current and past services/interventions which provides substantiation for CHECKED response as stated above:

Provider	Currently in Service?	Dates of Services/ Interventions	Outcomes/Current Progress
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		

Exhibits difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior.

☐ Yes ☐ No

Describe current symptoms and behaviors or other pertinent information which provides substantiation for CHECKED response (Identify frequency, intensity, and duration of each behavior):

Member's Full Name: Medicaid #:

Individual must meet ONE of the following; check applicable criteria:	
Services far more intensive than outpatient clinic care are required to stabilize the individual in the family situation. **Describe pertinent information which provides substantiation for CHECKED response (ex. What services have been tried and with what result, Describe severity and intensity of behaviors):**	☐ Yes ☐ No
The individual's residence as the setting for services is more likely to be successful than a clinic. **Describe pertinent information which provides substantiation for CHECKED response. If services are going to be performed in alternative service location outside the home setting, please indicate the reason and how interventions will be integrated and generalized into the individual's primary place of residence:**	☐ Yes ☐ No

SECTION II: CARE COORDINATION

Primary Care Physician:

Other medical/behavioral health concerns (including substance abuse issues, developmental/cognitive impairments) that could impact services? ☐ Yes ☐ No (If yes, explain below.)

Please indicate other current medical/behavioral services and additional community supports and interventions being received:

Name of service/treatment	Provider/Contact Information	Frequency

Indicate plan to coordinate with primary care physician and other treatment providers/services to help ensure treatment interventions are coordinated:

SECTION III: TRAUMA-INFORMED CARE

Trauma-Informed Care (Many individuals have experienced potentially traumatic events in their lifetime. It is important that everyone is aware of the potential impact of trauma on those they serve, prepare to recognize and offer trauma-specific services when needed, and be mindful of trauma-informed interventions.)

Is there evidence to suggest this member has experienced trauma?	☐ Yes ☐ No

What is your plan to assess/refer and address the current and potential effects of that trauma?

Member's Full Name: Medicaid #:

SECTION IV: INDIVIDUAL TREATMENT GOALS
Treatment Goals/Progress: • Describe person-centered, recovery-oriented, trauma-informed mental health treatment goals as they relate to requested treatment. Include individual strengths/barriers/gaps in service, and written in own words of individual seeking treatment/or in a manner that is understood by individual seeking treatment. If individual has identified a history of trauma, please include trauma-informed care interventions in the treatment plan. • Services are intended to include goal directed training/interventions that will enable individuals to learn the skills necessary to achieve or maintain stability in the least restrictive environment. Providers should demonstrate efforts to assist the individual in progressing toward goals to achieve their maximum potential. • Please demonstrate that the individual is benefiting from the service as evidenced by objective progress toward goals or modifications and updates that are being made to the treatment plan to address areas with lack of progress. • Include any appointments and medications adherence issues and plans to address this, if applicable.
Resources and Strengths: Document individual's strengths, preferences, extracurricular/community/social activities and people the individual identifies as supports.
Please describe any barriers to treatment:
How many hours each week will at least one family member be committed to participate in treatment?
How many hours per week of on-site supervision or direct counseling/therapy by an LMHP Type will be provided:
If no in-home counseling/therapy is provided in the home, why, and who is providing therapy/counseling and what is the frequency?
Goal/Objective (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):
Please describe where the member is now regarding this specific objective.
How many days per week will be spent addressing this goal on average?
What specific counseling and interventions that will be provided to address this goal?

Member's Full Name: Medicaid #:

How will you measure progress on the counseling or interventions provided?
Goal/Objective (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):
Please describe where the member is now regarding this specific objective.
How many days per week will be spent addressing this goal on average?
What specific counseling and interventions that will be provided to address this goal?
How will you measure progress on the counseling or interventions provided?
Goal/Objective (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):
Please describe where the member is now regarding this specific objective.
How many days per week will be spent addressing this goal on average?
What specific counseling and interventions that will be provided to address this goal?

Member's Full Name: Medicaid #:

How will you measure progress on the counseling or interventions provided?

SECTION V: DISCHARGE PLANNING		
DISCHARGE PLAN (Identify lower levels of care, natural supports, warm-hand off, care coordination needs)		
Step Down Service/Supports	Identified Provider/Supports	Plan to assist in transition
Recommended level of care at discharge:		
Estimated date of discharge:		

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

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

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

Credentials: _____

Date: _____

If any additional CMHRS services were recommended by the assessment or addendum referenced above, please identify the services here:

Member's Full Name: Medicaid #:

NOTES SECTION
If needed, use this page for any answer too long to fit within the form's provided spaces. Please note which section you are continuing before each answer.