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**	
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

Describe Care Coordination activities with these other services/supports since the last authorization. *There must be documented active coordination of care with other service providers. If care coordination is not successful, the reasons are documented, and efforts to coordinate care continue.*

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. Updated Crisis Education and Prevention Plan(CEPP), with evidence of support system involvement.

Section III: RECOVERY and DISCHARGE PLANNING

Discharge plans are an important tool to emphasize hope and plans for recovery. Planning for discharge from services should begin at the first contact with the individual. Recovery planning should include discussion about how the individual and service providers will know that the individual has made sufficient progress to move to a lower, less intensive level of care or into full recovery with a maintenance plan. ***These responses should reflect any updated understanding of the recovery and discharge plan since the last review.***

What would progress/recovery look like for this individual?

What barriers to progress/recovery can the individual, their natural supports, and/or the service provider identify?

What types of outreach, additional formal services or natural supports, or resources will be necessary to reach progress/recovery?

At this time, what is the vision for the level of care this individual may need at discharge from this service?

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