## MENTAL HEALTH SERVICES OF CATAWBA COUNTY

Service Authorization Request Form

**Date:** ________________ ***Type of Request:*** ☐*Agency Change* ☐*Continuing* ☐*Decrease* ☐*Increase* ☐*New* ☐*Transfer* ☐*Termination*

**Case Information: MR#:** _______ **Consumer name:** ________________________________ **DOB:** ______________
*Disability Group:* ☐*Mental Health* ☐*Developmental Disability* ☐*Substance Abuse*
*NC-SNAP (DD Consumers only):* *Comp score* ______ Current GAF score (on last face to face visit): ____________
Effective Date of Current PCP: _______________ Submitted to LME: Yes ☐ No ☐

***Children & Adolescents Only:*** *Team School Meeting:* ☐Yes ☐No *Meeting Date:* ______________________
*Attendees:* ______________________________________________________________________________

**Diagnoses:** ☐ See Attached Plan
AXIS I –
AXIS II –
AXIS III –
AXIS IV –

| Medications | Dosage & Route | Schedule | Medication compliant? | Target Symptoms |
|---|---|---|---|---|
| | | | ☐Yes ☐No | |
| | | | ☐Yes ☐No | |
| | | | ☐Yes ☐No | |
| | | | ☐Yes ☐No | |
| | | | ☐Yes ☐No | |

**ASAM Risk Rating for Substance Abuse** (if applicable) ASAM level: ______
A higher risk rating indicates greater level of severity and/or intensity
1. Withdrawal/Intoxication ☐Lo ☐Med ☐Hi
2. Medical Conditions ☐Lo ☐Med ☐Hi
3. Behavioral/Emotional/Cognitive Conditions ☐Lo ☐Med ☐Hi
4. Readiness for Change (Low Readiness = High Risk) ☐Lo ☐Med ☐Hi
5. Relapse/Continued use or problem potential ☐Lo ☐Med ☐Hi
6. Recovery Environment ☐Lo ☐Med ☐Hi

***Justification for Requested Services:***

**CURRENT NEEDS, BEHAVIORS, SYMPTOMS, AND FUNCTIONING LEVEL** (include school/work/home/community):
**Current Impairments:** (please select/circle one value for each type of impairment) 0=none, 1=mild or mildly incapacitating, 2=moderate or moderately incapacitating, 3=severe or severely incapacitating, n/a=not assessed for this impairment
Mood Disturbance (Depression or Mania) 0 1 2 3 n/a
Anxiety 0 1 2 3 n/a
Psychosis/Hallucinations/Delusions 0 1 2 3 n/a
Thinking/Cognition/Memory/Concentration 0 1 2 3 n/a
Impulsive/Reckless 0 1 2 3 n/a
Activities of Daily Living Problems 0 1 2 3 n/a
Medical/Physical Conditions 0 1 2 3 n/a
Job/School Performance Problems 0 1 2 3 n/a
Social/Relationships/Marital/Family Problems 0 1 2 3 n/a
Legal Problems 0 1 2 3 n/a
Substance Use 0 1 2 3 n/a
Select All that apply: ☐Alcohol ☐Illegal Drugs ☐Prescription Drugs ☐Abstinence ☐Controlled Use ☐Periods of Sobriety
Weight Loss Associated with Eating Disorder 0 1 2 3 n/a
Select One: ☐Gain ☐Loss ☐n/a of ______pounds in last 3 months Current weight:________lbs ☐n/a Height:_______ft_______in ☐
**Behavioral problems:** Severity Level (please select/circle one value for each behavior) 0=none, 1=mild 2=moderate 3=severe n/a=not assessed
Verbal Aggression 0 1 2 3 n/a
Physical Aggression 0 1 2 3 n/a
Combativeness 0 1 2 3 n/a
Sexual Aggression 0 1 2 3 n/a
Wanderer 0 1 2 3 n/a
Run away 0 1 2 3 n/a
Injurious to property 0 1 2 3 n/a
Injurious to self 0 1 2 3 n/a
Injurious to others 0 1 2 3 n/a
Other Inappropriate Behavior_________________0 1 2 3 n/a
**Functional Limitations:**
Vision: ☐Normal ☐Impaired ☐Blind Hearing: ☐Normal ☐Deaf ☐Other_________
Speech: ☐Normal ☐Non-communicative ☐Gestures ☐Echolalic
**Personal Care:**
Bathing: ☐Independent ☐With Assistance ☐Total Assistance Dressing: ☐Independent ☐With Assistance ☐Total Assistance
**Ambulation:** ☐Independent ☐Ambulatory with assistance ☐Non-ambulatory/mobile ☐Non-ambulatory/non-mobile
***Since last authorization, rate overall functioning:*** ☐*New service request* ☐*No change* ☐ *Significantly increased* ☐*Significantly Decrease* ☐ *Somewhat decreased* ☐*Somewhat increased*

**CURRENT CLINICAL RISK ASSESSMENT:**
Risk to Self (SI): ☐Not present ☐Ideation ☐Plan ☐Means ☐Assessed for hospitalization ☐Prior attempt, date____________
Risk to Others (HI): ☐Not present ☐Ideation ☐Plan ☐Means ☐Assessed for hospitalization ☐Prior attempt, date____________
Recent Abuse/Neglect/Exploitation: Yes ☐ No ☐ If yes, please describe event(s) & impact:

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**MR#:** ________________ **Consumer name:** ____________________ **Date:** ______________

***Natural/Community Supports:*** Please check all strengths/supports that are in place for this consumer:
☐Consumer's family/supports involved in treatment. ☐Care has been coordinated with other behavioral health providers.
☐Care has been coordinated with medical providers. ☐ A Psychiatrist has evaluated consumer.
☐Child Protection ☐Legal System ☐Employer ☐Other______________________
List specific conditions of court/DSS, if required to be addressed in treatment (include any commitment orders):

***Since last authorization, rate the use of natural supports:*** ☐new service request ☐No change ☐Significantly increased ☐Significantly decreased ☐Somewhat increased ☐somewhat decreased
***Natural Supports to be developed:***

**Treatment History (past 12 months):** Please check all that apply: ☐MH ☐SA ☐DD
List treatment types:

**Outcome**: ☐Unknown ☐Improved ☐No change ☐Worse **Tx Compliance**: ☐Unknown ☐Poor ☐Fair ☐Good

**Reason for Continued Treatment:** ☐Remains Symptomatic ☐Prepare for discharge/transition to another level of care within coming month ☐Conduct Family Therapy ☐Stabilize medications ☐Has not achieved treatment goals ☐Maintenance/Early Recovery ☐Facilitate return to work ☐Facilitate return to home ☐Finalize discharge plan ☐Other______________________

**Expected Results/Outcomes from Treatment**: At admission: ☐Holds job ☐Symptom Free ☐Manages Meds/Med Compliant ☐Abstinent ☐Functions Independently/ADLs Satisfactory ☐Public School Setting ☐Return to Home ☐Independent Living ☐Resolve Legal Issues ☐Other______________________
At re-authorization: ☐Holds job ☐Symptom Free ☐Manages Meds/Med Compliant ☐Abstinent ☐Functions Independently/ADLs Satisfactory ☐Public School Setting ☐Return to Home ☐Independent Living ☐Resolve Legal Issues ☐Other______________________

**Discharge/Transition Plan:** Barriers to Discharge: ☐Discharge treatment setting not available ☐Transportation ☐Legal Mandate ☐Adequate Housing/Residence ☐Community Supports not fully developed ☐Treatment Non-compliance ☐Other______________________
Describe plan to move to a less intensive level of care/services:

**Clinical Summary**: (Include progress since last authorization. Explain clinical outcomes that support medical necessity for continuation, increase or reduction in services)

### FINANCIAL AUTHORIZATION:

**Contact Information:** Provider: ______________________ Contact Name: ______________________
Payment Source:______________ Fax #: ______________ Callback #: ______________ E-Mail Address: ______________
DSS is Guardian? Yes☐ No☐ DJJ will pay? Yes☐ No☐ MH Pays Room & Board Only? Yes☐ No☐
Is the request for residential services for a child with private insurance? Yes☐ No☐ (Attach insurance denial)

**Services to be authorized**: *Number of months ☐ 1 ☐ 2 ☐ 3* *☐Request for entire date range* *☐Request for monthly date range*

| Service Code | Start Date | End Date | #Units/Hours/Days | Funding Source |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

**Submitting Provider Signature:** ______________________ **Date:** ______________

**For LME Use only:**
**Days & Specific Hours/Units Authorized Restrictions (i.e. # of hours/units/days/weeks/months):** ______________________

**Clinical Authorization:** ______________________ **Date:** ______________
**Financial Authorization:** ______________________ **Date:** ______________
**Authorization Number:** ______________________

**Notes:**
- *Signature indicates that the provider claims responsibility for current and ongoing verification of funding source and eligibility.*
- *Authorization does not guarantee payment in the event that eligibility or funding source changes.*
- *Reauthorization supercedes previous authorization.*

*UM:*