APS Healthcare

****Please Fax Completed Forms to APS Healthcare: 1-866-247-7588****

MEMBER INFORMATION
(*verify eligibility before providing services*)
Member Name :
Member ID#:
Plan Name:

Today's Date: _____
CPT Code: _____
Start Date of Auth: _____
Frequency of Contact: ☐ Weekly ☐ Monthly ☐ Other _____

PROVIDER INFORMATION

Auth #:
Provider Information:

Phone: Fax:

DSM-IV DIAGNOSIS

Axis I: ___ Axis II: ___ Axis III: ___ Axis IV: ___ Axis V (current): ___ Highest past yr:

RISK ASSESSMENT

Suicidal Risk

☐ not present ☐ ideation ☐ plan ☐ means
☐ prior attempt (date: _____)

Homicidal Risk

☐ not present ☐ ideation ☐ plan ☐ means
☐ prior attempt (date: _____)

Current Risk

☐ 1 (low) ☐ 2 ☐ 3 ☐ 4 ☐ 5 (high)
*if 3 or higher, briefly explain: _____

STATUS OF 3 MOST SIGNIFICANT TARGETED GOALS SINCE TX INITIATION

N=New Goal 1=Much Worse 2=Somewhat Worse 3=No Change 4=Slight Improvement 5=Major Improvement R=Resolved

Goals/Status-Letter/Number using above scale.
1.
2.
3.

MEMBER'S STRENGTHS/RESOURCES

Check all that apply:
☐ Positive Family Network
☐ Positive peer support
☐ Spiritual/Cultural involvement
☐ Interest in work/volunteer activity
☐ Realistic, positive expectations/goals for future
☐ Good problem-solving skills/able to seek help when needed
☐ Natural supports
☐ Good physical health/self-care
☐ Stable home setting
☐ Involvement in positive activities/interests
☐ Good self-awareness/self-understanding
☐ Other

CURRENT RISK INDICATORS (over last 3 months, where applicable)

Check all that apply:
☐ Current substance abuse
☐ Caring for ill family member
☐ Self-mutilation/cutting
☐ Sexually offending behavior
☐ Non-compliance with treatment
☐ Lack of supports (social, financial, etc.)
☐ Trauma Hx (Physical, Sexual, etc.)
☐ Risk of harm to self/others without support
☐ Hx repeated disturbances in the community
☐ Current family violence (abuse, domestic)
☐ Coping with significant loss (job, relationship, financial)
☐ Prior psychiatric inpatient admission (date: ___)
☐ No change from previous review in this tx episode
☐ Fire setting
☐ Impulsive Behavior
☐ Assaultive Behavior
☐ Psychotic Symptoms
☐ Harm to animals
☐ Corrections/court involvement
☐ Homelessness or "At risk for…"
☐ Truancy
☐ Other

CURRENT MEDICATIONS

Are Psychotropic meds being prescribed?
☐ Yes ☐ No

If yes, prescribed by:
☐ MD ☐ RN,CS/NP ☐ PCP

Prescriber:

List Meds:
1. ___ 2.
3. ___ 4.

Compliant with Meds? ☐ Yes ☐ No

If no psych meds, has evaluation been considered? ☐Yes ☐ No

Have you communicated with member's PCP ☐ and/or with prescriber ☐?

TREATMENT STATUS

Please rate the member's response to treatment since last review or since start of treatment if this is first review.

	Much Worse	Slightly Worse	No Changes	Slight Imprvmnt	Major Imprvmnt
Behavioral Symptoms that are focus of treatment	☐	☐	☐	☐	☐
Ability to perform Work/school/household tasks	☐	☐	☐	☐	☐

DISCHARGE

Member will be ready for Discharge when the following is achieved:

_____

Estimated Date of D/C: _____

Provider Signature: _____

Disclaimer: Authorization of care is based on eligibility and benefits at the time services are rendered. This authorization is not a guarantee of payment. Claims are verified to ensure that pre-authorization approval and claims information is consistent, that the patient is eligible for services at the time of treatment, that all services are covered by the Health Plan, and that all benefit requirements have been satisfied, including co-pays, deductibles, and limits, such as pre-existing conditions

Attention: Clinical Department; **Fax: 1-866-247-7588** 7125 Columbia Gateway Drive, Suite 250, Columbia, MD 21046