FORWARDHEALTH

PRIOR AUTHORIZATION INTENSIVE IN-HOME MENTAL HEALTH / SUBSTANCE ABUSE SERVICES ASSESSMENT AND RECOVERY / TREATMENT PLAN ATTACHMENT

The use of this form is voluntary and optional and may be used in place of the member's assessment and recovery/treatment plans. Providers may use their own assessment and treatment plan forms as long as all the elements and documentation requirements for strength-based assessment and recovery and treatment planning are included, or they may use this form, which includes the assessment, the multi-agency treatment plan, and the in-home recovery/treatment plan. Both a multi-agency treatment plan and an in-home treatment plan are required. These plans may be combined, making sure all required elements are included.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member	3. Member Identification Number

SECTION II — INITIAL PRIOR AUTHORIZATION REQUEST

4. Date of Initial Assessment / Reassessment

5. Presenting Problem

6. Diagnoses, including all five axes (Use current *Diagnostic and Statistical Manual of Mental Disorders* [DSM] / *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* [DC: 0-3] code and description.)

   Axis I _____

   Axis II _____

   Axis III _____

   Axis IV (List psychosocial/environmental problems.) _____

   Axis V (Current Global Assessment of Functioning [GAF].) _____

7. Symptoms (List member's symptoms in support of given DSM / DC:0-3 diagnoses.)

   Severity of Symptoms ❒ Mild ❒ Moderate ❒ Severe

8. Strength-Based Assessment (Member strengths, and current as well as historical psychological, social, and physiological data. Include mental status, developmental, cognitive functioning, school, vocational, cultural, social, spiritual, medical, past and current traumas, substance use / dependence and outcome of treatment, and past mental health treatment and outcome. Include the member's view of the issues; for a child, give the parent / primary caregiver's view. An assessment dated within three months of the request may be attached.)

9. Describe the member's and caregiver's unique perspectives and own words about how he or she views his or her recovery, experience, challenges, strengths, needs, recovery goals, priorities, preferences, values and lifestyle, areas of functional impairment, family and community support.

10. Describe anticipated barriers / strengths toward member's progress and improved functioning.

11. Has there been a consultation to clarify diagnosis / treatment? ❒ Yes ❒ No
    If yes, by whom?

    ❒ Psychiatrist ❒ Ph.D. Psychologist ❒ Master's-Level Psychotherapist

    ❒ Advanced Practice Nurse Prescriber-Psychiatry / Mental Health Specialty

    ❒ Substance Abuse Counselor ❒ Other (Specify) _____

    Date of Latest Consultation _____

    ❒ Attach report.

Continued

SECTION III — SUBSEQUENT PRIOR AUTHORIZATION REQUESTS

12. Indicate any changes in Elements 1-8, including the current Global Assessment of Functioning, change in diagnoses (five axes), and symptoms in support of new diagnosis, including mental status.

13. Describe current symptoms / problems.

- ❒ Anxiousness
- ❒ Appetite Disruption
- ❒ Decreased Energy
- ❒ Delusions
- ❒ Depressed Mood
- ❒ Disruption of Thoughts
- ❒ Dissociation
- ❒ Elevated Mood
- ❒ Guilt
- ❒ Hallucinations
- ❒ Homicidal
- ❒ Hopelessness
- ❒ Hyperactivity
- ❒ Impaired Concentration
- ❒ Impaired Memory
- ❒ Impulsiveness
- ❒ Irritability
- ❒ Manic
- ❒ Obsessions / Compulsions
- ❒ Oppositional
- ❒ Panic Attacks
- ❒ Paranoia
- ❒ Phobias
- ❒ Police Contact
- ❒ Poor Judgment
- ❒ School Problems
- ❒ Self-Injury
- ❒ Sexual Issues
- ❒ Sleeplessness
- ❒ Somatic Complaints
- ❒ Substance Use
- ❒ Suicidal
- ❒ Tangential
- ❒ Tearful
- ❒ Violence
- ❒ Worthlessness

❒ Other _____

SECTION IV — IN-HOME RECOVERY / TREATMENT PLAN

Document the goals and specific objectives to meet those goals on the recovery/treatment plan that is based on the strength-based assessment. Document the signs of improved functioning that will be used to measure progress toward specific objectives at identified intervals, agreed upon by the provider and member.

14. Treatment plan, as agreed upon with the member.

Short term (Three months) _____

Long term (Within the next year) _____

	What are the therapist / member agreed-upon signs of improved functioning?	Describe progress since last review.	Changes in Goal / Objective
1.			
2.			
3.			
4.			

Continued

SECTION IV — IN-HOME RECOVERY / TREATMENT PLAN (Continued)

15. How are member's strengths being utilized?

16. Indicate the rationale for in-home treatment. For an initial prior authorization (PA) request, elaborate on this choice where prior outpatient treatment is absent or limited. For a continuing PA request, if little or no progress is reported, discuss why the provider believes further treatment is needed and how the provider plans to address the need for continued treatment. What strategies will the provider, as the therapist, use to assist the member in meeting his or her goals? If progress is reported, give rationale for continued services.

17. Indicate the expected date for termination of in-home treatment. Describe anticipated service needs and detailed aftercare plans following completion of in-home treatment and transition plans.

18. Is member taking any psychoactive medication? ❒ Yes ❒ No

Name / Credentials of Prescriber _____

Date of Last Medication Check _____

19. If yes, list psychoactive medications and dosages.

Medication and Dosages _____ Target Symptoms _____

Medication and Dosages _____ Target Symptoms _____

Medication and Dosages _____ Target Symptoms _____

Is informed consent current for all medications? ❒ Yes ❒ No

SECTION V — MULTI-AGENCY TREATMENT PLAN

The multi-agency treatment plan must be developed by representatives from all systems identified on the severe emotional disturbance eligibility checklist and address the role of each system in the overall treatment and the major goals for each agency involved.

20. Individual Coordinating the Multi-agency Planning

A.	**Social Services Agency**	Names — Agency Team Members

Current Services Provided

Long Term Goal (Measurable)

Short Term Goals (Measurable)

Intervention (Include the frequency of the intervention and team member (s) responsible.)

Describe progress since last review.

B.	**Child Protective Services Agency**	Names — Agency Team Members

Current Services Provided

Long Term Goal (Measurable)

Short Term Goals (Measurable)

Intervention (Include the frequency of the intervention and team member[s] responsible.)

Describe progress since last review.

Continued

SECTION V — MULTI-AGENCY TREATMENT PLAN (Continued)

C.	**School Agency**	Names — Agency Team Members

Current Special Education Services Provided

Long Term Goal (Measurable)

Short Term Goals (Measurable)

Intervention (Include the frequency of the intervention and team member[s] responsible.)

Describe progress since last review.

D.	**Juvenile Justice Agency**	Names — Agency Team Members

Current Services Provided

Long Term Goal (Measurable)

Short Term Goals (Measurable)

Intervention (Include the frequency of the intervention and team member[s] responsible.)

Describe progress since last review.

E.	**Other Agency**	Names — Agency Team Members

Current Services Provided

Long Term Goal (Measurable)

Short Term Goals (Measurable)

Intervention (Include the frequency of the intervention and team member[s] responsible.)

Describe progress since last review.

SECTION VI — SIGNATURES

21. **SIGNATURE** — Certified Psychotherapist / Substance Abuse Counselor	22. Credentials	23. Date Signed
24. **SIGNATURE** — Member / Legal Guardian		25. Date Signed