Psychosocial Service Authorization Request Form

SECTION I

MCO (check one) ☐**HealthKeepers, Inc.** ☐**Beacon/Humana** ☐**Virginia Premiere**

Individual's Name:		Provider:
		Provider Address:
DOB:		
Initial Assessment Date:	Medicaid #:	Assessor's Name:
Admission Date to Psychosocial Services:	Retro Review? ☐Yes ☐No	Phone:

Request for approval of Psychosocial Services from (date)_______________to (date) ______________ for a total of _____units of service.

Diagnostic Information	*List of Known Medical Conditions*
Axis I:	
Axis II:	
Axis III:	
Axis IV:	
Axis V:	

List of Current Medications Prescribed				
Name of Medication	Dosage	Frequency	Name of Prescriber	Past Medication Compliance Issues
				☐Yes ☐No
				☐ Yes ☐No
				☐ Yes ☐No
				☐ Yes ☐No

SECTION II

Does the individual have an Integrated Care Plan that was designed by the MCO Care Team?
☐Yes (Proceed to Section IV) ☐No (Complete Sections III and IV).

SECTION III

PSYCHOSOCIAL ELIGIBILITY CRITERIA:	
Client must meet two of the following; check applicable criteria:	
Has difficulty in establishing or maintaining interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness because of conflicts with family or community.	
Requires help in basic living skills, such as maintaining personal hygiene, preparing food and maintaining adequate nutrition, or managing finances to such a degree that health or safety is jeopardized.	
Exhibits such inappropriate behavior that repeated interventions by the mental health, social services or judicial system are necessary.	
Exhibits difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior.	
In addition, the client must meet one of the following; check applicable criteria:	
Has experienced long-term or repeated psychiatric hospitalization.	
Lacks daily living skills and interpersonal skills.	
Has a limited or nonexistent support system.	
Unable to function in the community without intensive interventions.	
Requires long-term services to be maintained in the community.	

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

TREATMENT GOALS (Describe mental health treatment goals as they relate to requested treatment
Goal:
Progress:
Lack of Progress:
Goal:
Progress:
Lack of Progress

PRIMARY CARE	
Does the individual have a PCP?	☐Yes ☐No
If yes, has there been communication with the PCP to provide updates regarding treatment and to coordinate care?	☐Yes ☐No
List any physical health conditions which require treatment:	

SECTION IV

Signature of QMHP **Date:**

I have received the Psychosocial Assessment completed by the QMHP signed above and the psychiatric history information. The client meets the criteria and is approved to receive psychosocial rehabilitative services.

Signature of LMHP **Date:**

Community Services Board: