PSYCHOSOCIAL REHABILITATION
INITIAL REQUEST

Member's Name:

Member's DOB:

Member's ID:

1) Provider Contact Name:

2) Provider Contact
   a. Phone Number:

   b. Email:

3) Is This a Retro Review: ☐ Yes ☐ No

   a. If Retro Request, Date provider was notified of Medicaid eligibility:

4) Admission Date:

5) Requested Start Date (if different):

6) Service Authorization End Date:

7) Units Requested:

8) What is DSM diagnosis/diagnoses? Primary Secondary

9) If there is a dual diagnosis of mental health and substance use disorders, are services integrated and is the treatment of any substance use disorder intended to positively impact the mental health condition? ☐ Yes ☐ No ☐ Not Applicable

10) Does the member demonstrate a mental, behavioral or emotional illness resulting in significant functional impairments in major life activities: ☐ Yes ☐ No

11) Member must meet **at least two** of the following:

a. Does the Member have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or homelessness or isolation from social supports? ☐ Yes ☐ No

b. Does the member require help with basic living skills such as personal hygiene, food prep and nutrition, managing finances to such a degree that health or safety is jeopardized? ☐ Yes ☐ No

c. Does member exhibit behaviors that require repeated interventions by the mental health. social services or judicial system? ☐ Yes ☐ No

d. Does the member exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior? ☐ Yes ☐ No

12) Member must meet **at least one** of the following:

a. Has the individual experienced long-term or repeated psychiatric hospitalizations: ☐ Yes ☐ No

b. Does the member lack daily living skills and interpersonal skills: ☐ Yes ☐ No

c. Does the member have a limited or non-existent support system: ☐ Yes ☐ No

d. Is the member unable to function in the community without intensive interventions: ☐ Yes ☐ No

e. Does the member require long-term services to be maintained in the community: ☐ Yes ☐ No

13) Current Symptoms/Behaviors:

a. Describe current symptoms and behaviors or other pertinent information which provides substantiation for Yes responses as they relate to questions 11-12 above **(Identify the frequency, intensity and duration of each behavior):**

b. Describe *mental health* treatment goals for the member including progress/lack of progress towards treatment goals, as they relate to requested treatment:

c. List any physical health conditions which require treatment:

d. List all medications (for physical and behavioral health conditions) that member is taking:

14) Does member have a PCP: ☐ Yes ☐ No

a. If yes, has there been communication with PCP to coordinate care? ☐ Yes ☐ No