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Fax Cover Sheet

Prior Authorization Request for Adult Behavioral Health Residential (BHRF)
and Adult Behavioral Health Therapeutic Homes (ABHTH)
FAX: (844)424-3976

Confidential

Date:	
To:	**Mercy Care Utilization Management; (844) 424-3976**
From:	
Agency:	
Fax #:	
Pages:	including cover sheet
Subject:	**PRIOR AUTHORIZATION REQUEST FOR ADULT BHRF AND ABHTH**

LOC Being Requested: ☐ **BHRF** ☐ **ABHTH**

Is member already in level of care requested/needing a transfer? ☐ yes ☐ no

Prior Authorization Request must include the following and cannot be reviewed unless packet is complete.

This fax transmission includes:

☐	Prior Authorization form including recommendations from Outpatient BHMP/ Medical director
☐	Psychiatric Evaluation dated within the last year
☐	Most recent ISP (must indicate plan of BHRF)
☐	Signed member and guardian agreement
☐	Last three psychiatric progress notes from outpatient psychiatric provider
☐	Psychiatric notes from inpatient hospital (including assessment and recent progress notes)
☐	Documentation of treatment services currently in place or referrals made within the last 90 days.
☐	Co-occurring, Personal Care Services, Transfer, Eating Disorder, Increased Staffing Addendums as needed
☐	Current medication sheet
☐	Any additional documentation that supports the need for this level of care

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*PLEASE NOTE THAT REQUESTS **WILL NOT** BE ACCEPTED UNLESS ALL SECTIONS ARE COMPLETED IN DETAIL WITH ALL SUPPORTING INFORMATION ATTACHED.*

Requested Level of Care: ☐ BHRF	☐ ABHTH	☐ member already in level of care/transfer	
Type of BHRF being requested? ☐ Basic	☐ Co Occuring	☐ PCS	☐ Eating Disorder
If requesting anything outside of Basic, addendum must be completed	☐ enhanced staffing	☐ 1:1	
MEMBER DEMOGRAPHICS			
Member Name:		**DOB:**	
AHCCCS ID:	**Health Plan:** ☐ ACC	☐ RBHA/SMI	☐ DDD
Current Status: ☐ T19	☐ NT19	☐ other primary/T19 secondary	
Current location of member: *(i.e. inpatient, home, jail, homeless)*			
How long at current location:	**If inpatient, where was member prior:**		
BEHAVIORAL HEALTH HOME			
BHH Site Name:		**Fax:**	
Requesting CM:	**Phone & Email:**		
Clinical Coordinator:	**Phone & Email:**		
Clinical Director:	**Phone & Email:**		
Treating OP BHMP Name and Credentials:			
OP BHMP Phone & Email:			
Member's Last Attended BHMP Appointment:			
Additional Team Contacts:			
LEGAL			
Legal Guardian:	**Legal Guardian Phone:**		
Advocate:	**Advocate Phone:**		
Is Member on ☐ COT	☐ Probation	*Provide details on legal history below (sex offender/level, children/adults, felony charges)*	
CLINICAL INFORMATION			
Diagnosis: *Include: ICD codes, Developmental Disabilities, Substance Related, and/or Medical/Physical Health Dx* 1. 2. 3. 4. 5.			

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Reason for Referral: (check all that apply and provide specific details in text box below)

- ☐ Self-harming behaviors
- ☐ Impulsive behaviors resulting in safety risk
- ☐ Physical and/or verbal aggression
- ☐ Inappropriate sexualized behaviors
- ☐ Unable to remain safe in lower level of care
- ☐ Needs to learn skills for self-care
- ☐ Substance Use
- ☐ Needs to learn names, dosage, and frequency of medications
- ☐ Eating disorder behaviors
- ☐ Overnight behaviors

For each item checked, please provide examples within the last 90 days to include a clear explanation of why the individual requires residential treatment and cannot be effectively treated in an outpatient setting.

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Current Psychiatric and Therapeutic Services Utilized: Please provide the following information for each service the individual has used or has been referred for to address reasons for referral.

1. Specific Name of Service(s): Example: therapist, counseling center, etc.
2. Referral or Intake Date: Please specify the date the individual was referred or first attended the service.
3. Frequency of Service: How often is the individual receiving this service? (e.g., weekly, bi-weekly, monthly)
4. Notes on Member's Progress or Barriers: Describe the individual's progress or lack of progress in treatment. Include any changes in their condition or behavior, improvements, setbacks, or any challenges (i.e. no capacity) faced during the course of therapy or psychiatric treatment.

Functioning: Provide a description of member's ability to complete activities of daily living (ADLs) and independent living skills (ILS). Be sure to describe specific observations of any deficits in ability or if member is independent.

1. Personal hygiene (bathing, dressing, toileting, continence management etc):

2. Independent living skills and household chores (cooking, cleaning, laundry etc):

3. Cognitive abilities: Please describe any conditions affecting thinking or memory, such as dementia, TBI or developmental disabilities:

Please indicate if member uses/requires the following:

☐ Wheelchair/Walker ☐ ADA restroom ☐ 1st Floor bedroom & bathroom (no stairs)

Please confirm the following:

☐ Member is capable of participating in and benefitting from BHRF/ABHTH treatment

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Behavioral Health Treatment Goals: *(specific, measurable, realistic, relevant, and with an appropriate time frame to support the need for treatment at the requested level of care)*

Tentative Discharge Plan from BHRF or ABHTH*: Please detail at least two appropriate step-down options including: placement and wraparound treatment services*

Plan A:

Plan B:

Does member require interpreter services? ☐ **Yes** ☐ **No**

If yes, please clarify need:

Does member have an income? ☐ **Yes** ☐ **No**

If YES, what is members monthly income?

If NO, what efforts is the team taking to address this?

If member has a preference for geographical location, please identify first and second preferences.

first choice second choice

Does member need to be placed in an all-male or all-female facility? no

If all-male or all-female is selected, please provide explanation:

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THE FOLLOWING MUST BE COMPLETED BY OUTPATIENT BEHAVIORAL HEALTH MEDICAL PROFESSIONAL OR MEDICAL DIRECTOR

OP BHMP recommendation: I am ☐ IN AGREEMENT ☐ NOT IN AGREEMENT with REQUESTED LEVEL OF CARE: ☐ BHRF ☐ ABHTH	
Clinical opinion/rationale of OP BHMP for level of care being requested:	
OP BHMP Name & Credentials:	
OP BHMP Signature:	Date:

Additional Required Signatures:

Clinical Director Name:	
Clinical Director Signature:	Date:
Case Manager Name:	
Case Manager Signature:	Date:

Member and Guardian agreement

Must be completed for ALL requests

Date of staffing where different levels of care were discussed, BHRF/ABHTH was identified as most appropriate, AND agreed upon by member and guardian Month Day Year
Member and guardian are aware of and in agreement with the following: ☐ BHRF is short term treatment, not housing ☐ BHRF is a voluntary level of care and facilities are not locked. Staff do not have authority to hold members against their will. If a member leaves the facility without authorization (AWOL), member will no longer be under staff supervision. ☐ Member may be required to pay portion of income for room and board ☐ Member is required to participate in any/all treatment activities offered ☐ Member is not able to come and go at will from the facility (BHRF is 24/7 supervision. No independent time.) ☐ AWOL will result in discharge/unable to readmit without a new prior authorization ☐ Member will be expected to step down when deemed appropriate ☐ Member must follow house rules as appropriate

Member:	Date:
Guardian:	Date:

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Disclaimer: *To ensure timely processing of this application, please provide a fully completed form along with all required clinical documents. This includes, but is not limited to, the following:*

- Psychiatric evaluation dated within the past year
- Last 3 psychiatric progress notes from the outpatient psychiatric provider and psychiatric notes from the inpatient hospital (if applicable)
- Current Medication Sheet
- Staffing note that specifically discusses BHRF
- Medical documentation of recent care specific to any request for PCS
- Any pertinent psychological/psychiatric testing or medical imaging reports
- Documentation of current substance diagnosis for any request for Co-occurring.
- Any addendums

Failure to submit all necessary documentation outlining the individual's specific needs, as well as the services provided by the outpatient treatment team, may result in a denial of the application due to insufficient clinical documentation.

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Transfer Request Addendum

Must be completed if member is already in level of care being requested, and team is requesting to move member to a different location

Where is member currently?
Requesting transfer to: ☐ same provider, different location ☐ new provider
What is the clinical rationale for requesting transfer to a different location/provider?
How long has the problem been occurring *(days, weeks, months)***?**
What is being done at current location in attempt to remedy/preserve placement?
What would be different if member moved to a different provider/location?

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Co-Occurring BHRF Addendum

Must be completed if requesting placement due to substance use

Substance Use History			
Substance(s) used	**Frequency**	**Amount**	**Date of last use**

Past history of treatment for substance use: *(please list any services member was referred to or used to address substance use. Please include description of service, dates referred/used, participation, and outcome)*

Current substance use diagnoses:

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Increased Staffing (Enhanced or 1:1) Addendum

Must be completed if increased staffing is being requested

What are the specific behaviors requiring the increased staffing *(describe behaviors in detail):*
How often are the behaviors currently occurring? *(provide frequency for each behavior as well as date of last occurrence):*
Past history of treatment including all attempts to manage above referenced behaviors: *(please list any services member was referred to, including: description of service, dates referred/ used, participation, and outcome)*

Increased Staffing (Enhanced or 1:1) Addendum (contiuned)

For 1:1 requests: Has member attempted BHRF with enhanced staffing? ☐ Yes ☐ No *If yes, please provide detailed explanation as to why this was not successful. If no, please provide detailed explanation as to what will be different if services is offered again.*
What is the plan to step member down from enhanced staffing? *(Please provide clear, measurable, and realistic plan indicating expectations to be accomplished in order for member to step down as well as plan to ensure continued success upon step-down*)

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Personal Care Services (PCS) Addendum

Must be completed if member needs hand over hand help

Medical diagnoses *(must show that hand-over-hand help is needed)*:
Please provide specifics on what type of hand over hand help member will require *(please describe tasks member is unable to do):*
Please provide specifics on how often member will need hand over hand help *(indicate how often help is needed for each task: daily, weekly, or occasionally, and how many hours per day):*
Please describe any specific accessibility needs or accommodations that would help ensure a safe living environment for member *(e.g., no stairs, grab bars in bathroom, ground-floor bedroom etc.):*

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Eating Disorder Addendum

Must be completed if requesting placement due to an Eating Disorder

Current height:	**Current weight:**
BMI:	**Amount of weight loss over last 3 months:**
Provide detailed explanation of eating disorder behaviors over the last 90 days:	
Weight trends over the last 90 days *(last 3 months of documented weight and BMI)***:**	
Past history of treatment for eating disorder:	
PCP Name & Phone Number:	
Date Last Seen by PCP:	**Is member medically stable?**
Current Medical Diagnosis:	
Current Medical Medications:	
Has member been hospitalized for medical reasons within the last three months:	
Please provide details of hospitalizations:	
Please attach current Labs and last medical progress note	