

This is the Maine Behavioral Health ASO, APS CareConnection® Authorization Request Form. This form is to be used by providers to submit requests for Continued Stay Reviews for MaineCare members and other consumers as appropriate.

Fields with a (*) next to them are required. Please submit this information via CareConnection. If necessary, you may complete and fax this form to APS Healthcare at (866) 325-4752. Please call APS Provider Relations with any questions (866) 521-0027.

Continued Stay Request Form

*Member Information	
*Member MaineCare ID:	
*Member First Name:	*Member Last Name:
* Date of Birth: ____/____/____	*Member SSN:

Guardian / Power of Attorney			
Guardian Organization: (if applicable) <input type="checkbox"/> Child Welfare <input type="checkbox"/> Elder Services <input type="checkbox"/> Office of Cognitive Disabilities	Guardian First Name:	M.I.	Guardian Last Name:
Phone Number:	Relationship to Member: <input type="checkbox"/> Family Member <input type="checkbox"/> Friend <input type="checkbox"/> Agency <input type="checkbox"/> Spouse <input type="checkbox"/> Other		
Guardian Street or P.O. Box: City/ Town State Country Zip Code	Additional Information:		

*Administrative Data	
*Authorization Type:	_____ Continued Stay Review
*Requested Start Date of Service:	
*Request Submission Date:	
*Review Type:	<input type="checkbox"/> Adult Mental Health <input type="checkbox"/> Children's Services <input type="checkbox"/> Grant Funded Adult Services <input type="checkbox"/> Nursing Home Services <input type="checkbox"/> Psychological Services <input type="checkbox"/> Substance Abuse Services

*Category of Service: **CHOOSE ALL THAT APPLY**

Adult Mental Health

- Community Integration
- Intensive Community Integration
- Intensive Case Management
- Assertive Community Treatment
- Daily Living Support Services
- Skills Development
- Day Supports
- Specialized Group Services
- Crisis Supports Services
- Hospital Services – Acute
- Home Based
- Group Psychotherapy
- Medication Management
- Psychotherapy
- PNMI
- Psychological Services
- Family Psycho Educational
- Community Rehabilitation Services
- Long-Term Supported Employment
- Baxter Fund services

Grant Funded Adult Services

- Community Integration
- Assertive Community Treatment
- Daily Living Support Services
- Community Rehabilitation Services

Nursing Home Services

- Nursing Home Services

Children’s Services

- Targeted Case Management
- Inpatient Services
- Private Psychiatric Facility
- Day Treatment
- Crisis Support Services
- Children’s Outpatient
- Family Psycho Educational
- Child Community Assertive Treatment (ACT)
- Medication Services
- Child & Family Behavioral Health Treatment (Community Based)
- Community Based Treatment for Children without Permanency
- Private Non Medical Crisis Unit
- Treatment Foster Care
- Children’s PNMI Service

Psychological Services

- Psychological Services

Substance Abuse Services

- Inpatient Substance Abuse
- Outpatient Substance Abuse
- Residential Substance Abuse - Rehab Adult
- Residential Substance Abuse - Rehab Adolescent
- Residential Substance Abuse - Halfway House
- Residential Substance Abuse - Extended Care
- Residential Substance Abuse - Extended Shelter

Location (for PNMI, Crisis Units and Hospitals):

Referral Date:

Location at Time of Referral:

Hospital Community

Date Worker Assigned:

***Requesting Agency/Facility**

*Requesting Facility/Agency Name:

*Requesting Staff First Name:

*Requesting Staff Last Name:

*Requesting Staff Phone (W/ Area Code):

U M/Supervisor Phone:

***Multiaxial Assessment**

Date of Diagnostic Assessment:	Axis I ICD-9 Diagnosis 2:
*Primary ICD-9 Diagnosis:	Axis II ICD-9 Diagnosis 1:
Co-occurring Primary ICD-9 Diagnosis:	Axis II ICD-9 Diagnosis 2:
Axis I ICD-9 Diagnosis 1:	Axis III Diagnosis:

***Axis IV – Psychosocial Stressors**

Problems in Family Relations:	<input type="checkbox"/> None/NA	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Problems in Friendship/Social Relations:	<input type="checkbox"/> None/NA	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Legal Issues:	<input type="checkbox"/> None/NA	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
School Problems:	<input type="checkbox"/> None/NA	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Work Problems:	<input type="checkbox"/> None/NA	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Custody/Placement Issues:	<input type="checkbox"/> None/NA	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Financial Difficulties:	<input type="checkbox"/> None/NA	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Problems in Living Situation:	<input type="checkbox"/> None/NA	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Physical Health:	<input type="checkbox"/> None/NA	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Problems With Access to Health Care:	<input type="checkbox"/> None/NA	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Other Psychosocial & Environmental Problems:	<input type="checkbox"/> None/NA	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe

***Axis V – GAF**

Axis V Current: (as appropriate)	
Since last authorization request, GAF score has:	<input type="checkbox"/> Increased <input type="checkbox"/> Decreased <input type="checkbox"/> Not Changed <input type="checkbox"/> Unknown/Not Applicable

*** Procedure Request**

*Service Code:	
*Frequency:	
*Start Date:	
*Billing Provider MaineCare ID:	
*Service Length:	
*Units:	
*End Date:	

***Symptoms/Behavior Summary (Required for Section 17 only)**

Has member become homeless or at risk of losing his or her current residence?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is member causing repeated disturbances in the community because of poor judgment or bizarre, intrusive, or ineffective behavior?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is member at great risk of arrest because of behavior which results from his or her psychiatric diagnosis, or is presently incarcerated because of such behavior?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does member present a clear risk of harming self or others without community supportive services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does member manifest great difficulty in caring for self, posing a threat to his or her life or limb without community support services?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Would member deteriorate clinically to a point of needing immediate medical or psychiatric hospitalization in the absence of prompt community services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Assessment Tool *(Required as appropriate):	Date LOCUS Completed (Most Recent): ____/____/____ LOCUS Composite Score: ____ (1-35) LOCUS Level of Care: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 Caregiver Questionnaire: ____ (1-99) Rater ID# _____ ASAM Level: <input type="checkbox"/> I <input type="checkbox"/> II.1 <input type="checkbox"/> II.5 <input type="checkbox"/> III.1 <input type="checkbox"/> III.3 <input type="checkbox"/> III.5 <input type="checkbox"/> III.7 <input type="checkbox"/> IV								
CAFAS / PECFAS *(Required as appropriate):	Date CAFAS/ PECFAS Completed (Most Recent): ____/____/____ School/Work/Preschool: __0 __10 __20 __30 Moods/Emotions: __0 __10 __20 __30 Home: __0 __10 __20 __30 Self-Harmful Behavior: __0 __10 __20 __30 Community: __0 __10 __20 __30 Substance Abuse (CAFAS Only): __0 __10 __20 __30 Behavior Towards Others: __0 __10 __20 __30 Thinking/Communication: __0 __10 __20 __30 <div style="text-align: right;">Total Score: _____</div> Rater ID# _____								
Agency Involvement: <i>Check all that apply</i>	<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> DHHS Adult Mental Health</td> <td><input type="checkbox"/> DHHS Child Welfare</td> </tr> <tr> <td><input type="checkbox"/> DHHS Elder Services</td> <td><input type="checkbox"/> Special Ed / 504</td> </tr> <tr> <td><input type="checkbox"/> Corrections (Court, JCCO, etc.)</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td><input type="checkbox"/> EAP</td> <td><input type="checkbox"/> None</td> </tr> </table>	<input type="checkbox"/> DHHS Adult Mental Health	<input type="checkbox"/> DHHS Child Welfare	<input type="checkbox"/> DHHS Elder Services	<input type="checkbox"/> Special Ed / 504	<input type="checkbox"/> Corrections (Court, JCCO, etc.)	<input type="checkbox"/> Other _____	<input type="checkbox"/> EAP	<input type="checkbox"/> None
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<input type="checkbox"/> EAP	<input type="checkbox"/> None								
Family/Social Involvement: <i>Check all that apply</i>	<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Family</td> <td><input type="checkbox"/> Spouse/Partner</td> <td><input type="checkbox"/> Friends</td> <td><input type="checkbox"/> Religious group</td> </tr> <tr> <td><input type="checkbox"/> Community Resources</td> <td><input type="checkbox"/> AA/NA or self-help group</td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>Rate Overall Level of Family Involvement in Treatment Goals: <input type="checkbox"/> 0 [none] <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 [significant]</p> <p>Rate Overall Level of Natural Supports Involvement with the Client/Family: <input type="checkbox"/> 0 [none] <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 [significant]</p>	<input type="checkbox"/> Family	<input type="checkbox"/> Spouse/Partner	<input type="checkbox"/> Friends	<input type="checkbox"/> Religious group	<input type="checkbox"/> Community Resources	<input type="checkbox"/> AA/NA or self-help group	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Family	<input type="checkbox"/> Spouse/Partner	<input type="checkbox"/> Friends	<input type="checkbox"/> Religious group						
<input type="checkbox"/> Community Resources	<input type="checkbox"/> AA/NA or self-help group	<input type="checkbox"/> Other _____							
*Psychiatric Medications									
*Is member prescribed medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
If yes, does member take medications as prescribed?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
Did you notify the member's PCP of this medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
Is the Member's PCP prescribing psychiatric medications to the member?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A								
Please list all currently prescribed psychiatric medications:									

Clinical Indicators Justifying Service Request

From the Current Symptoms/Behavior columns, select the time period that describes the individual's most recent occurrence for each indicator that applies.

Name Of Symptom:	Indicate Current Severity: None, Mild, Moderate, Severe	Indicate History of Severity: Within 7 days; Within 8-90 days; Within 3-12 months; Within 1-10 years; 10+ years
Risk/Danger to Self/Others		
Aggressive:		
Fire Setting:		
Assaultive:		
Homicidal Attempt:		
Homicidal Ideation:		
Self Care Deficit:		
Self-Injurious Behavior:		
Sexually Inappropriate Behavior:		
Suicide Attempt:		
Suicidal Ideation:		
Use of Weapons:		
Harm to Animals:		
Symptoms and Behavior		
Anxiety/Panic:		
Attachment Problems:		
Depressed Mood:		
Dissociative Symptoms:		
Grandiose/Hyper-Religious:		
Hopeless/Helpless:		
Hyperactive:		
Hypervigilance:		
Impulsive:		
Insomnia:		
Irritable:		
Lying/Manipulative:		
Obsessions/Compulsions:		
Oppositional Behavior:		
Phobias:		
Property Destruction:		
Psychomotor Agitation:		
Psychomotor Retardation:		
Racing Thoughts:		
Running Away:		
Sexually Inappropriate Behavior:		
Separation Problems:		
Social Withdrawal:		

Stealing:		
Trauma-Related Symptoms:		
Truancy:		
Verbal Aggression:		
Thoughts, Attention and Cognition		
Decreased Concentration:		
Dementia:		
Disorganized Thinking:		
Distractible:		
Hallucinations:		
Paranoid:		
Poor Judgment:		
Thought Disorder:		
Drugs and Alcohol		
S A Related Medical Problems:		
Over the Counter Medications:		
Alcohol Use/Abuse:		
Illicit Drug Use/Abuse:		
Prescription Drug Use/Abuse:		

Answer the following questions to the best of your knowledge

***Treatment and Service History (required as appropriate)**

Select the tool or tools used to screen for co-occurring mental health and substance use disorders. Next to each selected tool, indicate if there were one or more YES responses. If the AC-OK is used, answer for all 3 domains. If the MHSF III is used, CRAFFT or UNCOPE must also be used.

This Tool Used: AC-OK MH Issues Domain	<input type="checkbox"/> Yes <input type="checkbox"/> No	This Tool Used: UNCOPE	<input type="checkbox"/> Yes <input type="checkbox"/> No
This Tool Used: AC-OK Trauma Issues Domain	<input type="checkbox"/> Yes <input type="checkbox"/> No	This Tool Used: CRAFFT	<input type="checkbox"/> Yes <input type="checkbox"/> No
This Tool Used: AC-OK Sub Abuse Issues Domain	<input type="checkbox"/> Yes <input type="checkbox"/> No	This Tool Used: MHSF III	<input type="checkbox"/> Yes <input type="checkbox"/> No

Date of assessment for co-occurring disorders:	
Have you communicated with the Member's PCP to coordinate mental health and physical health care?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> N/A
Is member receiving integrated MH/SA services?	<input type="checkbox"/> No <input type="checkbox"/> Yes
How long has member been receiving this service:	
How many times has member been seen by your service within this authorization period?	
Number of Inpatient Admissions in last 12 Months:	<input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5 or more
Number of ER or other crisis episodes last 12 months:	<input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5 or more
Number of years of active mental health treatment:	<input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5 or more
Number of lifetime homeless episodes:	<input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5 or more
Number of lifetime jail / prison terms:	<input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5 or more
Currently on probation/parole or conditional release?	<input type="checkbox"/> No <input type="checkbox"/> Yes
For youth in school, number of suspensions last 12 months:	<input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5 or more
For youth under age 18, number of times run away for over a 24 hr period:	<input type="checkbox"/> 0 <input type="checkbox"/> 1-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5 or more

***RDS (Required only for Section 17 CI, ICI, ICM, and ACT services)**

***ISP Status: Initial ISP 90 Day review of ISP Annual review of ISP Person w/ ISP left CSS Program**

Needed resources – Check All That Apply

<u>Mental Health Services</u>	Date Identified	Date Satisfied	No Longer Needed
<input type="checkbox"/> Assertive Community Treatment (ACT)	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Community integration Services	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Dialectical Behavioral Therapy	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Family Psycho-Educational Treatment Services	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Group Counseling	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Individual Counseling	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Inpatient Psychiatric Facility	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Intensive Case Management Services	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Intensive Community Integration Services	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Psychiatric Medication Management	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Other Mental Health Services _____	_____	_____	<input type="checkbox"/>

<u>Mental Health Crisis Planning Resources</u>	Date Identified	Date Satisfied	No Longer Needed
<input type="checkbox"/> Development of Mental Health Crisis Plan	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Development of Mental Health Advance Directives	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Other Mental Health Crisis Planning Resources _____	_____	_____	<input type="checkbox"/>

<u>Peer Recovery and Support Resources</u>	Date Identified	Date Satisfied	No Longer Needed
<input type="checkbox"/> Peer Recovery Center	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Recovery Workbook Workgroup	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Social Club	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Peer-Run Trauma Recovery and Empowerment Group	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Wellness Recovery and Action Planning	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Family Support	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Other Peer Recovery and Support Resources _____	_____	_____	<input type="checkbox"/>

<u>Substance Abuse Services</u>	Date Identified	Date Satisfied	No Longer Needed
<input type="checkbox"/> Outpatient Substance Abuse Services	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Residential Treatment Substance Abuse Services	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Other Substance Abuse Services _____	_____	_____	<input type="checkbox"/>

<u>Housing Resources</u>	Date Identified	Date Satisfied	No Longer Needed
<input type="checkbox"/> Supported Apartment	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Community Residential Facility	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Residential Treatment Facility	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Assisted Living Facility	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Nursing Home	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Residential Crisis Unit	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Rent Subsidy	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Other Housing Resources _____	_____	_____	<input type="checkbox"/>

<u>Health Care Resources</u>	Date Identified	Date Satisfied	No Longer Needed
<input type="checkbox"/> Dental Services	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Eye Care Services	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Hearing Services	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Physical Therapy	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Physician Medical Services	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Other Health Care Resources _____	_____	_____	<input type="checkbox"/>

<u>Legal Resources</u>	Date Identified	Date Satisfied	No Longer Needed
<input type="checkbox"/> Advocates	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Guardian (Private)	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Guardian (Public)	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Other Legal Resources _____	_____	_____	<input type="checkbox"/>
<u>Financial Security Resources</u>	Date Identified	Date Satisfied	No Longer Needed
<input type="checkbox"/> Assistance with Managing Money	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Assistance with Securing Public Benefits (e.g. SSI, TANF, Food Stamps, General Assistance, MaineCare)	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Representative Payee	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Other Financial Security Resources _____	_____	_____	<input type="checkbox"/>
<u>Education Resources</u>	Date Identified	Date Satisfied	No Longer Needed
<input type="checkbox"/> Adult Education (Other than GED)	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> GED	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Literacy Assistance	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Post High School Education (Incl. 2 and 4 yr courses of study)	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Tuition Reimbursement Related to Employment Goals	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Other Education Resources _____	_____	_____	<input type="checkbox"/>
<u>Vocational/Employment Resources</u>	Date Identified	Date Satisfied	No Longer Needed
<input type="checkbox"/> Benefits Counseling Related to Employment	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Club House/Transitional and/or Peer Vocational Support	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Competitive Employment (No Supports)	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Supported Employment	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Vocational Rehabilitation	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Other Vocational/Employment Resources _____	_____	_____	<input type="checkbox"/>
<u>Living Skills Resources</u>	Date Identified	Date Satisfied	No Longer Needed
<input type="checkbox"/> Daily Living Support Services	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Day Support Services	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Occupational Therapy	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Skills Development Services	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Other Living Skills Resources _____	_____	_____	<input type="checkbox"/>
<u>Transportation Resources</u>	Date Identified	Date Satisfied	No Longer Needed
<input type="checkbox"/> Transportation to ISP - Identified Services	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Transportation to other ISP - Identified Activities	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> After Hours Transportation (Evenings and Weekends)	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Other Transportation Resources _____	_____	_____	<input type="checkbox"/>
<u>Personal Growth/Community Participation Resources</u>	Date Identified	Date Satisfied	No Longer Needed
<input type="checkbox"/> Avocational Activities	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Recreation Activities	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Social Activities	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Spiritual Activities	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Other Personal Growth/Comm. Participation Resources _____	_____	_____	<input type="checkbox"/>
<u>Other Resources</u>	Date Identified	Date Satisfied	No Longer Needed
<input type="checkbox"/> Other Resources _____	_____	_____	<input type="checkbox"/>

***Individual Treatment Plan**

***Describe member's strengths and skills (Check all that apply) :**

- | | |
|--|--|
| <input type="checkbox"/> Positive family network | <input type="checkbox"/> Positive peer support |
| <input type="checkbox"/> Interest in work/volunteer activity | <input type="checkbox"/> Realistic, positive expectations and goals for future |
| <input type="checkbox"/> Good problem-solving skills/ able to seek help when needed | <input type="checkbox"/> Spiritual/Cultural involvement |
| <input type="checkbox"/> Natural Supports | <input type="checkbox"/> Good physical health/self-care |
| <input type="checkbox"/> Stable home setting | <input type="checkbox"/> Involvement in positive activities/interests |
| <input type="checkbox"/> Good self-awareness/self-understanding | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Consumer's strengths are incorporated into the treatment plan | |

Is the member or caregiver involved in forming the Individual Treatment Plan?	__ Yes __ No
List those involved with the development of the plan:	
Member's expectations of treatment and perception of needs:	
Family/Caregiver's expectation of Tx and perception of member's needs:	
Disabilities and accommodations required for the delivery of the service:	
Justification for not addressing needs identified in the assessment:	
Unmet needs:	
Potential barriers to treatment:	
Criteria for discharge:	
Is Substance Abuse an issue: __ Yes __ No	Type of Substance:
Amount/Frequency of Use:	Length of Use/Last Use:
*Date Current Treatment Plan was developed:	____/____/____
*Date Next Treatment plan is to be developed:	____/____/____
Comments:	

***Treatment Plan Goals**

Problem Statement:		
*Long Term Goal:	*Target Date:	Progress since last review:
*Short Term Goal:	*Target Date:	Progress since last review:

Interventions:	Services to be Provided:
	Frequency of Services:
	Duration of Services:
	Provider of Services:

Add a second goal below (if applicable):

Problem Statement:			
*Long Term Goal:	*Target Date:	Progress since last review:	
*Short Term Goal:	*Target Date:	Progress since last review:	
Interventions:	Services to be Provided:		
	Frequency of Services:		
	Duration of Services:		
	Provider of Services:		

Additional Required Reporting Data (As Required)	
Current Living Situation:	<input type="checkbox"/> Homeless Shelter or on the Streets <input type="checkbox"/> Own Apartment or Home <input type="checkbox"/> Temporarily Staying with Others <input type="checkbox"/> Supported Apartment <input type="checkbox"/> Community Residential Facility <input type="checkbox"/> Residential Treatment Facility (Group Home Arrangement) <input type="checkbox"/> Nursing Home <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Residential Crisis Unit <input type="checkbox"/> Riverview Psychiatric Center <input type="checkbox"/> Dorothea Dix <input type="checkbox"/> Other Psychiatric Inpatient Unit or Facility <input type="checkbox"/> Hospitalized for Medical Reasons <input type="checkbox"/> Incarcerated in a State Prison or County Jail <input type="checkbox"/> Other: _____ <input type="checkbox"/> Foster Care
Does the Member Receive a Rent Subsidy?	<input type="checkbox"/> No <input type="checkbox"/> Yes

Current Vocational/ Employment Status:	<input type="checkbox"/> Volunteer <input type="checkbox"/> Sheltered / Enclave Worker <input type="checkbox"/> Self-Employed <input type="checkbox"/> Currently Receiving Vocational Rehabilitation Services <input type="checkbox"/> Competitively Employed Full-Time (32 or more hrs per week) <input type="checkbox"/> Competitively Employed Part-Time (Less than 32 hrs per week) <input type="checkbox"/> Working with Supports Full-Time (32 or more hrs per week) <input type="checkbox"/> Working with Supports Part-Time (Less than 32 hrs per week) <input type="checkbox"/> Not Employed – Not Looking for Work <input type="checkbox"/> Not Employed – Looking for Work <input type="checkbox"/> Other: _____
Does the Member Receive Vocational Rehab Services?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was the member involved with the legal system/ police within the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Since the last authorization period has the member missed a significant number of days of school?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

*Transition Discharge Plan- Check all that Apply	
Is Discharge Anticipated During the Authorization Period? <input type="checkbox"/> Yes <input type="checkbox"/> No	Projected Date of Transition/Discharge: _____ / _____ / _____
Anticipated Step Down Service: First Appt. Post Discharge Day/Mo	Anticipated Step Down Service: First Appt. Post Discharge Day/Mo
<input type="checkbox"/> Natural Supports	<input type="checkbox"/> 65M&N
<input type="checkbox"/> Respite	<input type="checkbox"/> Adult Home Based Services
<input type="checkbox"/> AA / NA	<input type="checkbox"/> DLSS
<input type="checkbox"/> Peer Support	<input type="checkbox"/> Substance Abuse Tx
<input type="checkbox"/> Outpatient	<input type="checkbox"/> Crisis Services
<input type="checkbox"/> Groups	<input type="checkbox"/> Crisis Unit
<input type="checkbox"/> Psychiatric / Med. Mgt.	<input type="checkbox"/> Fost / Child Welfare
<input type="checkbox"/> Case Management / C.I.	<input type="checkbox"/> Adult Protective
<input type="checkbox"/> Section 24	<input type="checkbox"/> Supported Nursing Facility
<input type="checkbox"/> Day Treatment	<input type="checkbox"/> Medical Hospitalization
<input type="checkbox"/> ACT / C.I.	<input type="checkbox"/> Residential Treatment
<input type="checkbox"/> Corrections	<input type="checkbox"/> Other
Plan for transition / Discharge:	

Additional Information

Please provide additional information to support request for services, as needed.

***Treatment Progress**

*Treatment Progress:	<input type="checkbox"/> Significant <input type="checkbox"/> Moderate <input type="checkbox"/> Minimum <input type="checkbox"/> None <input type="checkbox"/> Deteriorated <input type="checkbox"/> Other _____
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*Provider Name: _____ *Date: _____

*Provider Signature: _____