

This is the Maine Behavioral Health ASO, APS CareConnection® Authorization Request Form. This form is to be used by providers to submit notifications of a transfer or discharge of 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.

### Transition/Discharge Form

*Member Information	
*Member MaineCare ID:	
*Member Last Name:	
*Member First Name:	
* Member SSN:	
* Date of Birth:	____/____/____
*Gender:	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unknown
*Requesting Agency/Facility	
*Requesting Facility/Agency Name:	
*Requesting Staff First Name:	
*Requesting Staff Last Name:	
*Requesting Staff Phone (W/ Area Code):	
Utilization Manager/Supervisor Phone:	
*Discharge Service	
*Procedure/Service Code:	
*Billing Provider MaineCare ID:	
*Admission/Start Date:	
PNMI/Crisis Unit Location:	
*Discharge Date:	
Was this Patient admitted involuntarily?: <input type="checkbox"/> Yes <input type="checkbox"/> No	
If this admission was involuntary, did this admission convert from involuntary to voluntary? : <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
<b>*Reason for Discharge:</b>  <i>Choose Only One, that Best Applies</i>	<input type="checkbox"/> Member and provider agree that treatment is complete based upon the individual's status, service needs, and mutually agreed upon goal attainment <input type="checkbox"/> Member or parent/guardian withdrew consumer from care <input type="checkbox"/> Member no longer meets medical necessity criteria <input type="checkbox"/> Member is no longer eligible for services <input type="checkbox"/> Member's lack of participation in program <input type="checkbox"/> Program's determination to discontinue services (due to member's actions, the services are not effective or the program is unable to secure the safety and welfare of the member or others). <input type="checkbox"/> Member moved from the service area <input type="checkbox"/> Elopement <input type="checkbox"/> Member is in jail/prison <input type="checkbox"/> Member aged out <input type="checkbox"/> Member deceased <input type="checkbox"/> Other _____ <input type="checkbox"/> Member transferred to another provider
Change in Level of Care: <i>Choose Only One</i>	<input type="checkbox"/> Member referred to less intensive level of care <input type="checkbox"/> Member referred to another provider providing similar level of services <input type="checkbox"/> Member referred to more intensive non-hospital level of care <input type="checkbox"/> Member is hospitalized-psychiatric <input type="checkbox"/> Member is hospitalized-somatic

**Anticipated Step Down Service: Check all services that must be in place upon discharge**

Service	Anticipated Date of First Appointment	Service	Anticipated Date of First Appointment
<input type="checkbox"/> Natural Supports	_____	<input type="checkbox"/> 65 M&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"/> Group	_____	<input type="checkbox"/> Crisis Unit	_____
<input type="checkbox"/> Psychiatric / Med.Mgt.	_____	<input type="checkbox"/> Foster/Child Welfare	_____
<input type="checkbox"/> Case Management/C.I.	_____	<input type="checkbox"/> Adult Protective	_____
<input type="checkbox"/> Section 24	_____	<input type="checkbox"/> Supported Nursing Fac	_____
<input type="checkbox"/> Day Treatment	_____	<input type="checkbox"/> Medical Hospitalization	_____
<input type="checkbox"/> ACT/I.C.I	_____	<input type="checkbox"/> Residential Tx	_____
<input type="checkbox"/> Corrections	_____	<input type="checkbox"/> Other	_____

Treatment Progress:  Significant  Moderate  Minimum  None  Deteriorated

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
Total Score: _____	

Living Situation Upon Discharge (Required as appropriate):	<input type="checkbox"/> Hospitalized for Medical Reasons
	<input type="checkbox"/> Incarcerated in a State Prison or County Jail
	<input type="checkbox"/> Rent Subsidy-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"/> Foster Care
	<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"/> Other: (specify) _____
Did the Hospital obtain the Member's ISP from their CI, ICI, ICM or ACT Provider?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Did the Hospital invite the Member's CI, ICI, ICM or ACT Provider to participate in treatment or discharge planning?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Did the Member's CI, ICI, ICM or ACT Provider participate in treatment or discharge planning? :	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Plan for Transition/ Discharge	

\*Provider Name: \_\_\_\_\_

\*Provider Signature: \_\_\_\_\_

\*Date: \_\_\_\_\_