APS Healthcare

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
John E. Baldacci, Governor   Brenda M. Harvey, Commissioner

This is the Maine Behavioral Health ASO, APS CareConnection® Authorization Request Form. This form is to be used by providers to submit requests for Prior Authorization 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.

Prior Authorization Request Form

*Member Information	
*Member MaineCare ID:	
*Member First Name:	*Member Last Name:
*Member SSN:	* Date of Birth: ___ /___ /______
*Gender: ☐Female ☐Male ☐Unknown	Phone Number (With Area Code):
*Address of Record Line 1:	
*City:	County:
*State:	*Zip Code:
*AMHI Consent Decree Class Member: ____Yes ___ No	
*Race:	__ White __ Black or African American __ Asian __ Native Hawaiian __ Other Pacific Islander __ American Indian __ Alaskan Native __ Other Race __ Unknown
*Ethnicity:	__ Not of Hispanic/Latino Origin – Franco-American __ Not of Hispanic/Latino Origin – Houlton Band of Maliseets __ Not of Hispanic/Latino Origin – Micmac __ Not of Hispanic/Latino Origin – Non Specific __ Not of Hispanic/Latino Origin – Other Native American __ Not of Hispanic/Latino Origin – Passamaquoddy __ Not of Hispanic/Latino Origin – Penobscot __ Of Hispanic/Latino Origin – Central American __ Of Hispanic/Latino Origin – Cuban __ Of Hispanic/Latino Origin – Mexican/Mexican-American __ Of Hispanic/Latino Origin – Other Hispanic/Latino __ Of Hispanic/Latino Origin – Puerto Rican __ Of Hispanic/Latino Origin – South American __ Unknown

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Guardian / Power of Attorney

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

*Administrative Data

*Authorization Type:
_____ Prior Authorization
_____ Grant Funded Prior Authorization
_____ Initial Courtesy Review

*Request Submission Date:	*Requested Start Date of Service:

*Review Type:
__ Adult Mental Health
__ Children's Services
__ Grant Funded Adult Services
__ Nursing Home Services
__ Psychological Services
__ 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

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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 Name / 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:	☐None/NA	☐Mild	☐Moderate	☐Severe
Problems in Friendship/Social Relations:	☐None/NA	☐Mild	☐Moderate	☐Severe
Legal Issues:	☐None/NA	☐Mild	☐Moderate	☐Severe
School Problems:	☐None/NA	☐Mild	☐Moderate	☐Severe
Work Problems:	☐None/NA	☐Mild	☐Moderate	☐Severe
Custody/Placement Issues:	☐None/NA	☐Mild	☐Moderate	☐Severe
Financial Difficulties:	☐None/NA	☐Mild	☐Moderate	☐Severe
Problems in Living Situation:	☐None/NA	☐Mild	☐Moderate	☐Severe
Physical Health:	☐None/NA	☐Mild	☐Moderate	☐Severe
Problems With Access to Health Care:	☐None/NA	☐Mild	☐Moderate	☐Severe
Other Psychosocial & Environmental Problems:	☐None/NA	☐Mild	☐Moderate	☐Severe

*Axis V – GAF	
Axis V Current: (as appropriate)	
Since last authorization request, GAF score has:	___ Increased ___ Decreased ___ Not Changed ___ Unknown/Not Applicable

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

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*Symptoms/Behavior Summary (Required for Section 17 only)	
Has member become homeless or at risk of losing his or her current residence?	__ Yes __ No
Is member causing repeated disturbances in the community because of poor judgment or bizarre, intrusive, or ineffective behavior?	__ Yes __ 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?	__ Yes __ No
Does member present a clear risk of harming self or others without community supportive services?	__ Yes __ No
Does member manifest great difficulty in caring for self, posing a threat to his or her life or limb without community support services?	__ Yes __ No
Would member deteriorate clinically to a point of needing immediate medical or psychiatric hospitalization in the absence of prompt community services?	__ Yes __ No

Assessment Tool *(Required as appropriate):	Date LOCUS Completed (Most Recent): ______/_______/______ LOCUS Composite Score: _____ (1-35) LOCUS Level of Care: □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 Caregiver Questionnaire: ________(1-99) Rater ID#______________________ ASAM Level: □ I □ II.1 □ II.5 □ III.1 □ III.3 □ III.5 □ III.7 □ 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: __________________ Rater ID#___________________
Agency Involvement: *Check all that apply*	☐DHHS Adult Mental Health ☐DHHS Child Welfare ☐DHHS Elder Services ☐Special Ed / 504 ☐Corrections (Court, JCCO, etc.) ☐Other ________________________ ☐EAP ☐None
Family/Social Involvement: *Check all that apply*	☐ Family ☐Spouse/Partner ☐ Friends ☐ Religious group ☐ Community Resources ☐ AA/NA or self-help group ☐ Other _______________ Rate Overall Level of Family Involvement in Treatment Goals: ☐ 0 [none] ☐ 1 ☐ 2 ☐3 ☐4 ☐ 5 [significant] Rate Overall Level of Natural Supports Involvement with the Client/Family: ☐0 [none] ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 [significant]

*Psychiatric Medications	
*Is member prescribed medication?	__ Yes __ No
If yes, does member take medications as prescribed?	__ Yes __ No
Did you notify the member's PCP of this medication?	__ Yes __ No
Is the Member's PCP prescribing psychiatric medications to the member?	__ Yes __ No __ 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		
Substance Abuse 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 __ Yes __ No
☐ This Tool Used: AC-OK Trauma Issues Domain __ Yes __ No
☐ This Tool Used: AC-OK Sub Abuse Issues Domain __ Yes __ No
☐ This Tool Used: UNCOPE __ Yes __ No
☐ This Tool Used: CRAFFT __ Yes __ No
☐ This Tool Used: MHSF III __ Yes __ No

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Question	Response
Date of assessment for co-occurring disorders:	
Have you communicated with the Member's PCP to coordinate mental health and physical health care?	__ No __ Yes __ N/A
Is member receiving integrated MH/SA services?	__ No __ 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:	□ 0 □ 1-2 □ 3-4 □ 5 or more
Number of ER or other crisis episodes last 12 months:	□ 0 □ 1-2 □ 3-4 □ 5 or more
Number of years of active mental health treatment:	□ 0 □ 1-2 □ 3-4 □ 5 or more
Number of lifetime homeless episodes:	□ 0 □ 1-2 □ 3-4 □ 5 or more
Number of lifetime jail / prison terms:	□ 0 □ 1-2 □ 3-4 □ 5 or more
Currently on probation/parole or conditional release?	__ No __ Yes
For youth in school, number of suspensions last 12 months:	□ 0 □ 1-2 □ 3-4 □ 5 or more
For youth under age 18, number of times run away for over a 24 hr period:	□ 0 □ 1-2 □ 3-4 □ 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

Mental Health Services	Date Identified	Date Satisfied	No Longer Needed
Assertive Community Treatment (ACT)	___________	___________	☐
Community integration Services	___________	___________	☐
Dialectical Behavioral Therapy	___________	___________	☐
Family Psycho-Educational Treatment Services	___________	___________	☐
Group Counseling	___________	___________	☐
Individual Counseling	___________	___________	☐
Inpatient Psychiatric Facility	___________	___________	☐
Intensive Case Management Services	___________	___________	☐
Intensive Community Integration Services	___________	___________	☐
Psychiatric Medication Management	___________	___________	☐
Other Mental Health Services______________	___________	___________	☐

Mental Health Crisis Planning Resources	Date Identified	Date Satisfied	No Longer Needed
Development of Mental Health Crisis Plan	___________	___________	☐
Development of Mental Health Advance Directives	___________	___________	☐
Other Mental Health Crisis Planning Resources______________	___________	___________	☐

Peer Recovery and Support Resources	Date Identified	Date Satisfied	No Longer Needed
Peer Recovery Center	___________	___________	☐
Recovery Workbook Workgroup	___________	___________	☐
Social Club	___________	___________	☐
Peer-Run Trauma Recovery and Empowerment Group	___________	___________	☐
Wellness Recovery and Action Planning	___________	___________	☐
Family Support	___________	___________	☐
Other Peer Recovery and Support Resources________________	___________	___________	☐

Substance Abuse Services	Date Identified	Date Satisfied	No Longer Needed
Outpatient Substance Abuse Services	___________	___________	☐
Residential Treatment Substance Abuse Services	___________	___________	☐
Other Substance Abuse Services______________	___________	___________	☐

Housing Resources	Date Identified	Date Satisfied	No Longer Needed
Supported Apartment	___________	___________	☐
Community Residential Facility	___________	___________	☐
Residential Treatment Facility	___________	___________	☐
Assisted Living Facility	___________	___________	☐
Nursing Home	___________	___________	☐
Residential Crisis Unit	___________	___________	☐
Rent Subsidy	___________	___________	☐
Other Housing Resources ________________	___________	___________	☐

Health Care Resources	Date Identified	Date Satisfied	No Longer Needed
Dental Services	___________	___________	☐
Eye Care Services	___________	___________	☐
Hearing Services	___________	___________	☐
Physical Therapy	___________	___________	☐
Physician Medical Services	___________	___________	☐
Other Health Care Resources______________	___________	___________	☐

Legal Resources	Date Identified	Date Satisfied	No Longer Needed
Advocates	___________	___________	☐
Guardian (Private)	___________	___________	☐
Guardian (Public)	___________	___________	☐
Other Legal Resources______________	___________	___________	☐

Financial Security Resources	Date Identified	Date Satisfied	No Longer Needed
Assistance with Managing Money	___________	___________	☐
Assistance with Securing Public Benefits (e.g. SSI, TANF, Food Stamps, General Assistance, MaineCare)	___________	___________	☐
Representative Payee	___________	___________	☐
Other Financial Security Resources __________________	___________	___________	☐

Education Resources	Date Identified	Date Satisfied	No Longer Needed
Adult Education (Other than GED)	___________	___________	☐
GED	___________	___________	☐
Literacy Assistance	___________	___________	☐
Post High School Education (Incl. 2 and 4 yr courses of study)	___________	___________	☐
Tuition Reimbursement Related to Employment Goals	___________	___________	☐
Other Education Resources______________	___________	___________	☐

Vocational/Employment Resources	Date Identified	Date Satisfied	No Longer Needed
Benefits Counseling Related to Employment	___________	___________	☐
Club House/Transitional and/or Peer Vocational Support	___________	___________	☐
Competitive Employment (No Supports)	___________	___________	☐
Supported Employment	___________	___________	☐
Vocational Rehabilitation	___________	___________	☐
Other Vocational/Employment Resources __________________	___________	___________	☐

Living Skills Resources	Date Identified	Date Satisfied	No Longer Needed
Daily Living Support Services	___________	___________	☐
Day Support Services	___________	___________	☐
Occupational Therapy	___________	___________	☐
Skills Development Services	___________	___________	☐
Other Living Skills Resources______________	___________	___________	☐

Transportation Resources	Date Identified	Date Satisfied	No Longer Needed
Transportation to ISP - Identified Services	___________	___________	☐
Transportation to other ISP - Identified Activities	___________	___________	☐
After Hours Transportation (Evenings and Weekends)	___________	___________	☐
Other Transportation Resources______________	___________	___________	☐

Personal Growth/Community Participation Resources	Date Identified	Date Satisfied	No Longer Needed
Avocational Activities	___________	___________	☐
Recreation Activities	___________	___________	☐
Social Activities	___________	___________	☐
Spiritual Activities	___________	___________	☐
Other Personal Growth/Comm. Participation Resources_________	___________	___________	☐

Other Resources	Date Identified	Date Satisfied	No Longer Needed
Other Resources_________________________	___________	___________	☐

*Individual Treatment Plan

Describe member's strengths and skills (Check all that apply) :	
	☐ Positive family network ☐ Positive peer support ☐ Interest in work/volunteer activity ☐ Realistic, positive expectations and goals for future ☐ Good problem-solving skills/ able to seek help when needed ☐ Spiritual/Cultural involvement ☐ Natural Supports ☐ Good physical health/self-care ☐ Stable home setting ☐ Involvement in positive activities/interests ☐ Good self-awareness/self-understanding ☐ Other: ☐ Consumer's strengths are incorporated into the treatment plan

Additional Required Reporting Data (As Required)

Current Living Situation:	
	__ Homeless Shelter or on the Streets __ Own Apartment or Home __ Temporarily Staying with Others __ Supported Apartment __ Community Residential Facility __ Residential Treatment Facility (Group Home Arrangement) __ Nursing Home __ Assisted Living Facility __ Residential Crisis Unit __ Riverview Psychiatric Center __ Dorothea Dix __ Other Psychiatric Inpatient Unit or Facility __ Hospitalized for Medical Reasons __ Incarcerated in a State Prison or County Jail __ Other: ______________________________ __ Foster Care

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

*Transition Discharge Plan- Check all that Apply	
Is Discharge Anticipated During the Authorization Period? __ Yes __ 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
☐ Natural Supports	☐ 65M&N
☐ Respite	☐ Adult Home Based Services
☐ AA / NA	☐ DLSS
☐ Peer Support	☐ Substance Abuse Tx
☐ Outpatient	☐ Crisis Services
☐ Groups	☐ Crisis Unit
☐ Psychiatric / Med. Mgt.	☐ Fost / Child Welfare
☐ Case Management / C.I.	☐ Adult Protective
☐ Section 24	☐ Supported Nursing Facility
☐ Day Treatment	☐ Medical Hospitalization
☐ ACT / C.I.	☐ Residential Treatment
☐ Corrections	☐ Other
Plan for transition / Discharge:	

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

*Provider Name: ____

*Provider Signature: ____

*Date: ____