PROJECT BRAVO
BEHAVIORAL HEALTH REDESIGN FOR ACCESS, VALUE & OUTCOMES

CLEAR FORM

THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

VIRGINIA'S MEDICAID PROGRAM DMAS

ASSERTIVE COMMUNITY TREATMENT (ACT: H0040)

INITIAL Service Authorization Request Form

Please be mindful of notes throughout this form providing reference to where documentation obtained during the Comprehensive Needs Assessment (CNA) is relevant and can be used for efficiency. There will also be sections in this form prompting creation of initial Individual Service Plan (ISP) goals, which providers must be complete prior to the start of services. Character limits have been established in most sections, please use the notes section to add additional information.

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name:		Organization Name:	
Member Last Name:		Group NPI #:	
Medicaid #:		Provider Tax ID #:	
Member Date of Birth:		Provider Phone:	
Gender:		Provider E-Mail:	
Member Plan ID #:		Provider Address:	
Member Street Address:		City, State, ZIP:	
City, State, ZIP:		Provider Fax:	
		Clinical Contact Name and Credentials*:	
		Phone #	
		* *The individual to whom the MCO can reach out to in order to gather additional necessary clinical information.*	

Request for Approval of Services: **Retro Review Request?** ○ Yes ○ No

If the member is currently receiving ACT, start date of service:

Proposed/Requested Service Information:

From_____(date), To_____(date), for a total of _____units of service.

Plan to provide_____hours of service per week.

Identify all known treatment periods of Assertive Community Treatment that have been provided by any providers including the requesting provider in the past 12 months:

Provider	Dates of Service/Intervention	Outcomes

Primary ICD-10 Diagnosis	
Secondary Diagnosis(es)	

Other medical/behavioral health concerns (including substance abuse issues, personality disorders, dementia, cognitive impairments) that could impact services? ○ Yes ○ No (If yes, explain below.)

SECTION I: ADMISSION CRITERIA

Individuals must meet ALL of the criteria #1-3; note that some criteria have multiple sub-criteria to consider.

1. Specify the DSM diagnosis corresponding with the ICD-10 diagnosis(es) on the previous page. (To meet criteria, the primary diagnosis should be a serious and persistent mental illness (i.e. schizophrenia spectrum or other psychotic disorders, bipolar and related disorders).*

   Describe the individual's current symptoms as well as their frequency, intensity and duration.
   The initial service and treatment plan proposed here should be reasonable to address these symptoms/diagnosis(es).
   Corresponding CNA Elements: 1, 12

**Individuals with psychiatric illnesses that fall outside the serious mental illness definition may be eligible depending on the level of associated long-term disability; in these cases, a Physician letter justifying this exception should accompany the service authorization request.*

Preliminary Treatment Goal #1: *Create a goal related to one or more of the symptoms noted above.*

2. Significant functional impairment as demonstrated by at least <u>one</u> of the following conditions (A, B, and/or C):
   Corresponding CNA Elements: 6, 7

A. The individual has significant difficulty in consistent performance of the range of routine tasks required for basic adult functioning in the community (e.g. caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers/hazards to self/possessions; meeting nutritional needs; attending to personal hygiene) **or** persistent/recurrent difficulty performing daily living tasks except with significant support/assistance from others such as friends, family, or relatives. *Describe the most significant difficulties in these areas for this individual below and connect them to the symptoms described in criteria 1:*	○ Yes ○ No
Preliminary Treatment Goal #2A: *Create a goal related to the difficulties in performing routine/daily living tasks*	
B. The individual has significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the head-of-household responsibilities (such as meal preparation, household tasks, budgeting, or child-care tasks and responsibilities). *Describe the most significant difficulties in these area for this individual below and connect these to the symptoms described in criteria #1:*	○ Yes ○ No
Preliminary Treatment Goal #2B: *Create a goal related to the difficulties in maintaining employment or carrying out head of household responsibilities.*	

C. The individual has significant difficulty maintaining a safe living situation (for example, repeated evictions or loss of housing or utilities). *Describe these difficulties in maintaining safe housing and connect these to the symptoms described in criteria #1:*	○ Yes ○ No

Preliminary Treatment Goal #2C: *Create a goal related to the difficulties in maintaining safe housing.*

3. The individual has <u>one or more</u> of the following problems, which are indicators of continuous high-service needs. Check the box next to each that apply for this individual and provide details as prompted:
Corresponding CNA Elements: 1, 2, 3, 7, 8

Problem Area	Check if applicable
A. High use of acute psychiatric hospitalization *Multiple admissions or at least one recent long-term stay of 30 days or more in the last 2 years List all admissions, including institution, dates of admission/discharge and outcomes.*	○ Yes ○ No
B. Persistent/recurrent, severe psychiatric symptoms *E.g. psychotic, affective, suicidal/homicidal ideation or intent, self-harm behaviors* *(If relevant, these should have been detailed in the response to Criteria #1)*	○ Yes ○ No

C. Co-existing mental health and substance use disorder difficulties for more than 6 months *(If relevant, these should have been detailed in the response to Criteria #1)*	○ Yes ○ No
D. High risk or recent history of experiencing criminal justice involvement (e.g. arrest, incarceration, probation) as a result of mental health disorder symptoms: *Describe all recent history in this domain that is related to the individual's mental health problem:*	○ Yes ○ No
E. Significant difficulty meeting basic survival needs or is *at imminent risk* of homelessness as a result of mental health disorder symptoms. *Provide any evidence of current, imminent risk to loss of housing that goes beyond any detail provided in 2c regarding more historical/chronic challenges with maintaining safe housing:*	○ Yes ○ No
F. The individual is residing in an inpatient setting (e.g. state hospital or other psychiatric hospital) or supervised community residence, but has been clinically assessed to be able to live in a more independent living situation if intensive services are provided; or requiring a residential or institutional placement if more intensive services are not available. *Provide name of current hospital and dates of service if not provided in the first box of this table.*	○ Yes ○ No

G. Difficulty in consistent participation in traditional office-based outpatient services. *Provide information on these difficulties in outpatient engagement, including names of past providers, dates of services, and information on the barriers to participation.*	◉ Yes ○ No

Preliminary Treatment Goal #3: *Create treatment goal related to one of the problems endorsed above.*

Section V: RECOVERY & DISCHARGE PLANNING

Discharge plans are an important tool to emphasize hope and plans for recovery. Planning for discharge from services should begin at the first contact with the individual. Recovery planning should include discussion about how the individual and service providers will know that the member has achieved sufficient progress to move to a lower, less intensive level of care or into full recovery with a maintenance plan.

What would progress/recovery look like for this individual?

What barriers to progress/recovery can the individual, their natural supports, and/or the service provider identify?

What types of outreach, additional formal services or natural supports, or resources will be necessary to reach progress/recovery?

At this time, what is the vision for the level of care this individual may need at discharge from this service?

What is the best estimate of the discharge date for this individual?

By my signature (below), I am attesting that 1) an LMHP, LMHP-R, LMHP-S or LMHP-RP has reviewed the individual's psychiatric history and completed the appropriate assessment or addendum; and 2) that this assessment indicates that the individual meets the medical necessity criteria for the identified service. The assessment or applicable addendum for this service was completed on the following date(s):

Signature (actual or electronic) of LMHP (Or R/S/RP): _____

Printed Name of LMHP (Or R/S/RP): _____

Credentials: _____

Date:

Notes Section