

THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

**MENTAL HEALTH INTENSIVE OUTPATIENT (MH-IOP: S9480) and MENTAL  
HEALTH PARTIAL HOSPITALIZATION PROGRAM (MH-PHP: H0035)  
CONTINUED STAY Service Authorization Request Form**

*Please be mindful of notes through this form that provide reference to where information requested herein aligns with documentation from the updated Comprehensive Needs Assessment (CNA) and/or Individualized Service Plan. Character limits have been established in most sections, please use the note 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:	
		<b>Clinical Contact Name and Credentials*:</b>	
		Phone #	
		* The individual to whom the MCO can reach out to in order to gather additional necessary clinical information.	

<b>Type of Service Authorization Request:</b>			
Mental Health Intensive Outpatient {S9480}			
Mental Health Intensive Outpatient with Occupational Therapy {S9480, GO}. Please place evidence of the need for OT Services in the Notes Section of this form.			
Mental Health Partial Hospitalization Program {H0035}			
<b>Initial date of admission to current service:</b>		<b>Average units provided per week:</b>	
<b>Request for Approval of Continued Services:</b>		<b>Retro Review Request?</b> Yes      No	
From _____ (date), To _____ (date), for a total of _____ units of service.			
Plan to provide _____ hours of service per week.			
<b>Primary ICD-10 Diagnosis</b>			
<b>Secondary Diagnosis(es)</b>			
<b>Medication Update</b>			
<b>Name of Medication</b>	<b>Dose</b>	<b>Frequency</b>	<b>For any changes, note if: New, Ended or Changed in dose/frequency from last authorization</b>



- Interventions should seek to achieve or maintain stability in the least restrictive environment possible. Thus, if a provider conducts an intervention in a more restrictive than natural environment (e.g. clinic), part of the intervention should be to translate the use of skills to the least restrictive environment (e.g. community).
- If more than one provider type is involved in the delivery of the service, the provider should list interventions specific to the scope of each relevant provider type in addressing the treatment goal and measuring progress.
- **Dosage of Intervention**
  - Treatment plan should include a description of the frequency in terms of days/hours the providers will deliver the interventions.
- **Treatment Progress**
  - Providers should describe progress in terms of the identified goals and objectives.
  - Providers should describe any alterations in goals or whether new goals have been established and why.
  - Goals and measurement may change over time as the provider's understanding of the problem evolves and/or as the individual may disclose new information or exhibit new behaviors that impact goals.
  - Continued stay authorization requires explanation of how the plan is evolving and how it will support recovery for the individual.
- **Resources and Strengths**
  - The treatment plan should include individual strengths, preferences, and resources that the individual identifies as relevant to their recovery.
- **Barriers**
  - The treatment plan should include a list of ongoing or evolving barriers to treatment, additional resources that would support the individual in overcoming these barriers, and a plan for how to address them.

#### 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 individual has made sufficient progress to move to a lower, less intensive level of care or into full recovery with a maintenance plan. ***These responses should reflect any updated understanding of the recovery and discharge plan since the last review.***

*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?*

Member Full Name:

Medicaid #:

*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**

Member Full Name:

Medicaid #:

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