

Member's Full Name:

Medicaid #:

# SERVICE AUTHORIZATION FORM

## THERAPEUTIC DAY TREATMENT (TDT) H2016 INITIAL Service Authorization Request Form

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:	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	Provider E-Mail:	
Member Plan ID #:		Provider Address:	
Member Address:		City, State, ZIP:	
City, State, ZIP:		Provider Fax:	
Parent/Guardian:		Clinical Contact Name & Credentials*:	
Parent/Guardian Contact Information:		Clinical Contact Phone:	
		* This is the individual to whom the MCO can reach out to answer additional clinical questions.	

<b>Procedure Code:</b> <input type="checkbox"/> H2016 (school day) <input type="checkbox"/> H2016 – UG (after-school) <input type="checkbox"/> H2016 – U7 (summer)	
<b>Provide the name of the school (and/or other setting) where these services are being provided:</b>  	
<b>Request for Approval of Services:</b> <b>Retro Review Request?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No From _____ (date), To _____ (date), for a total of _____ units of service. Plan to provide _____ hours of service per week.	
<b>Is this a new service for the member?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, then complete an authorization for continuing care.)	
<b>Primary ICD-10 Diagnosis</b>	
<b>Secondary Diagnosis</b>	

Name of Medication	Dosage	Frequency

If additional medications are prescribed, include listing of medications, dosage, and frequency in the Notes section.



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<b>Individual must meet <u>ONE</u> of the following; check applicable criteria:</b>	
<b>The individual must require year-round treatment to sustain behavior or emotional gains</b>  Describe pertinent information which provides substantiation for CHECKED response (ex. What services have been tried and with what result, Describe severity and intensity of behaviors):	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>The individual's behavior and emotional problems are so severe that they cannot be handled in a self-contained or resource emotionally disturbed (ED) classroom without:</b> a. TDT programming during the school day or b. TDT programming to supplement the school day or school year  Describe pertinent information which provides substantiation for CHECKED response:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>The individual would otherwise be placed on homebound instruction because of severe emotional/behavioral problems that interfere with learning.</b>  Describe pertinent information which provides substantiation for CHECKED response:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>The individual must have deficits in social skills, peer relations or dealing with authority, are hyperactive, have poor impulse control, are extremely depressed or marginally connected with reality.</b>  Describe pertinent information which provides substantiation for CHECKED response:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>The individual is placed or pending placement in a preschool enrichment and or early intervention program but the individuals emotional/behavioral problems are so severe that it is documented that they cannot function or be admitted to these programs without TDT services.</b>  Describe pertinent information which provides substantiation for CHECKED response:	<input type="checkbox"/> Yes <input type="checkbox"/> No

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**SECTION II: CARE COORDINATION**

**Primary Care Physician:**

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

**Please indicate other current medical/behavioral services and additional community supports and interventions being received:**

Name of service/treatment	Provider/Contact Information	Frequency

**Indicate plan to coordinate with primary care physician and other treatment providers/services to help ensure treatment interventions are coordinated:**

**SECTION III: TRAUMA-INFORMED CARE**

**Trauma-Informed Care** (Many individuals have experienced potentially traumatic events in their lifetime. It is important that everyone is aware of the potential impact of trauma on those they serve, prepare to recognize and offer trauma-specific services when needed, and be mindful of trauma-informed interventions.)

**Is there evidence to suggest this member has experienced trauma?**  Yes  No

**What is your plan to assess/refer and address the current and potential effects of that trauma?**

**SECTION IV: INDIVIDUAL TREATMENT GOALS**

**Treatment Goals/Progress:**

- Describe person-centered, recovery-oriented, trauma-informed mental health treatment goals as they relate to requested treatment. Include individual strengths/barriers/gaps in service, and written in own words of individual seeking treatment/or in a manner that is understood by individual seeking treatment. If individual has identified a history of trauma, please include trauma-informed care interventions in the treatment plan.
- Services are intended to include goal directed training/interventions that will enable individuals to learn the skills necessary to achieve or maintain stability in the least restrictive environment. Providers should demonstrate efforts to assist the individual in progressing toward goals to achieve their maximum potential.
- Please demonstrate that the individual is benefiting from the service as evidenced by objective progress toward goals or modifications and updates that are being made to the treatment plan to address areas with lack of progress.
- Include appointments and medications adherence issues and plans to address this, if applicable.

**Resources and Strengths:** Document individual's strengths, preferences, extracurricular/community/social activities and people the individual identifies as supports.

**Please describe any barriers to treatment:**

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<b>Please describe how coordination of TDT services will occur with school personnel and identified family member(s) involved in individual's care on a daily/weekly basis (i.e. treatment meetings, progress reports, correspondence with family, etc.):</b>
<b>Goal/Objective</b> (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):
<b>How many days per week will be spent addressing this goal on average?</b>
<b>What specific counseling and/or behavioral interventions will be provided to address this goal?</b>
<b>How many hours per week of onsite supervision or direct counseling/therapy by an LMHP Type will be provided?</b>
<b>If no in-school counseling/therapy is provided, why, and who is providing therapy/counseling and what is the frequency?</b>
<b>Goal/Objective</b> (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):
<b>How many days per week will be spent addressing this goal on average?</b>
<b>What specific counseling and/or behavioral interventions will be provided to address this goal?</b>
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**If no in-school counseling/therapy is provided, why, and who is providing therapy/counseling and what is the frequency?**

**Goal/Objective** (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):

**How many days per week will be spent addressing this goal on average?**

**What specific counseling and/or behavioral interventions will be provided to address this goal?**

**How many hours per week of onsite supervision or direct counseling/therapy by an LMHP Type will be provided?**

**If no in-school counseling/therapy is provided, why, and who is providing therapy/counseling and what is the frequency?**

**SECTION V: DISCHARGE PLANNING**

**DISCHARGE PLAN** (Identify lower levels of care, natural supports, warm-hand off, care coordination needs)

Step Down Service/Supports	Identified Provider/Supports	Plan to assist in transition

Recommended level of care at discharge:

Estimated date of discharge:

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

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

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

Credentials & NPI: \_\_\_\_\_

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

If any additional CMHRS services were recommended by the assessment or addendum referenced above, please identify the services here:

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**NOTES SECTION**

**If needed, use this page for any answer too long to fit within the form's provided spaces. Please note which section you are continuing before each answer.**