

Member First Name:

Member Last Name:

Member Date of Birth:

Medicaid #:

Gender:

**MEMBER INFORMATION** 





PROVIDER INFORMATION

## MULTISYSTEMIC THERAPY (H2033) 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), as well as the Background Information and Strengths and Needs Assessment (MST-related documents) are relevant and can be used for efficiency. The Weekly Case Summary Form (used in MST Supervision/Consultation) will serve as the Individualized Service Plan for this service, and thus this form does not reference ISP Goals.

**Organization Name:** 

Group NPI #:

Provider Tax ID #:

Provider Phone:
Provider F-Mail:

Member Plan ID #:		Provider Address:				
Member Street Address:		City, State, ZIP:				
City, State, ZIP:		Provider Fax:				
Member Phone #:  Legal Guardian Name/Contact Information (If applicable):		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 Appr	oval of Services				
Retro Review Request? Yes						
If the member is currently receiving this service, start date of service:  Proposed/Requested Service Information:  From(date), To(date), for a total of						
Identify all known treatment provi		apy that have been provided by any providers				
Provider	Dates of Service/Intervention	Outcomes				
Primary ICD-10 Diagnosis						
Secondary Diagnosis(es)						

Other medical/behavioral health concerns (including substance use issues, personality disorders, dementia,		
cognitive impairments) that could impact services? Yes No (If yes, explain below.)		
	CECTION I. ADMICCION CRITERIA	
	SECTION I: ADMISSION CRITERIA	
	dividuals must meet ALL of the criteria #1-7; note that some criteria have multiple sub-criteria for consideration.	
1.	What is the youth's age?	
If t	he youth is outside of the range of 11 to 18 years old, please provide information in regards to the need for and	
арі	propriateness of this service.	
2.	Specify the DSM diagnosis corresponding with the ICD-10 diagnosis(es) on the previous page. (To meet criteria, the	
	primary diagnosis must be in the areas of disruptive behavior, mood, substance use, or traumatic stress).	
	Describe the individual's current symptoms (including frequency, intensity and duration) and areas of functional impairment.	
	Corresponding CNA Elements: 1,6, 7, 12	

<b>3.</b> Within the past 30 calendar days, the youth has demonstrated <u>at least one</u> of the following that puts the youth at risk of out-of-home placement:		
A. Persistent and deliberate attempts to intentionally inflict serious injury on another person. Describe the details from this individual's experience; note that citing dates (when feasible) of these attempts helps to verify the criteria.	Yes	
	No	
B. Ongoing dangerous or destructive behavior.  Describe any repeated occurrences of behaviors that are endangering to self or others, are difficult to control, cause distress, or negatively affect the youth's health.	Yes	
	No	
C. Increasing and persistent symptoms associated with depression or anxiety in combination with externalizing behaviors that have contributed to decreased functioning in the community.  Symptoms were detailed in Question 1. Please provide any additional details to characterize how symptoms have been increasing or persistent over the last 30 calendar days.	Yes	
	No	

D. Ongoing substance use or dependency that interfere with the youth's interpersonal relationships and functioning in the community. Please provide details here: What substance(s), use patterns and specific impacts on functioning?	Yes
	No
E. The youth is returning home from an out-of-home placement and MST is needed as a step-down service.  Please provide the name of the placement, details concerning the youth's behavior and why the youth was admitted, any behavioral health treatment the youth received, and the youth's response to this treatment.	Yes
	No
4. Describe how the youth's successful reintegration or maintenance in the community is dependent upon a integrated and coordinated treatment approach that involves intensive family/caregiver partnership and MST model presents a unique fit for this youth's problem behaviors. Why is MST the best fit for this youth	how the

5. Please provide information on the identity and relationship of any identified family member(s)/caregiver(s)	
available to participate in MST services with the youth.	
6. Describe the arrangements for supervision at home/community that will ensure a reasonable degree of safety for participation in this service. If the youth/natural supports/provider have established a safety plan, you may cite plan and attach to this service authorization request.	
Section V: RECOVERY & DISCHARGE PLANNING	
Discharge plans are an important tool to emphasize hope and plans for recovery. Planning for discharge should be the first contact with the individual. Recovery planning should include discussion about how the individual and ser providers will know that the member has achieved sufficient progress to move to a lower, less intensive level of ca into full recovery with a maintenance plan.  Within MST, completion of the Background Information Form and the Initial Strengths and Needs Assessment as we general fidelity to the model within supervision and consultation may serve to demonstrate these questions are being considered and thus the provider may attach those forms rather than filling out this section.  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?	vice re or

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:		
Signature (actual or electronic) of LMHP (Or R/S/RP):		
Printed Name of LMHP (Or R/S/RP):		
Cradontials		
Credentials:		
Date:		
Notes		

Member Full Name:	Medicaid #: