

**Community Based CM**



**Group B**

**ADULT MENTAL HEALTH DIVISION**

**Service Authorization Request**

**PURPOSE**

To promote the appropriate level of services and treatment for registered consumers.

Fax Completed Form To: AMHD Utilization Management

PHONE NUMBER: 586-7400 FAX NUMBER: 453-6966 Fax Date: \_\_\_\_\_

Reason for form completion:

Admission  Continued Stay  Discharge

**CONSUMER INFORMATION** (Type or Print Clearly)

Name: \_\_\_\_\_ Alias: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: HI Zip Code: \_\_\_\_\_

Current DX Code, Axis I: \_\_\_\_\_ Current DX Code, Axis II: \_\_\_\_\_

Axis III: \_\_\_\_\_ Axis IV: \_\_\_\_\_ Axis V: \_\_\_\_\_

Other Benefit Coverage: \_\_\_\_\_ Policy #: \_\_\_\_\_

Consumer assigned to team:

ALL ISLANDS:

Standard

OAHU ONLY:

HIV  Geriatric  Borderline PD  Homeless & at risk of homelessness

**PROVIDER CONTACT INFORMATION**

Provider Agency: \_\_\_\_\_ Submitted by: \_\_\_\_\_

Provider Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: HI Zip: \_\_\_\_\_



Name of Consumer: \_\_\_\_\_ Community Based CM

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**Admission Criteria**

**Admit Date:**

Meets **all** of the following:

1.  Consumer is capable of living in the community either in supportive or independent settings, and may not require intensive supervision or very frequent contact in order to access needed services
2.  Consumer is in need of advocacy, support or any AMHD authorized service.
3.  Moderate or less functional impairment as evidenced by at least one of the following:
  - a.  Troubled significant relationships but impulsive or abusive behaviors are under control
  - b.  Appearance and hygiene are below usual standards on a frequent basis
  - c.  Serious disturbances in vegetative activities but not serious threat to health
  - d.  Neglect or avoidance on some occasions of ability to fulfill social or vocational responsibilities and obligations
  - e.  Deficits in interpersonal relationships but able to engage in socially constructive activities
  - f.  Recent stabilization has been achieved through structured and/or protected setting
4.  Either there is no co-morbidity or, if a medical or substance abuse problem exists, the problem may not adversely affect, or be adversely affected, by the presenting disorder to the extent that it may require acute hospitalization or immediate long term care placement
5.  Consumer's environment may be moderately stressful with limited or few supports but more intensive intervention is not necessary in order for consumer to access needed services and supports.

**Continued Stay Criteria**

**Continued Date:**

Meets **all** of the following:

1.  Continues to meet initial criteria
2.  In order to maintain current community stability, requires this level of service at least 1 time per month, face-to-face contact with case manager
3.  There is documented evidence that consumer is showing stabilization/improvements in the areas of functional status, increased environmental supports, and engagement to reasonably conclude that continued services at this level will further stabilize/increase consumer's functioning



Name of Consumer: \_\_\_\_\_ Community Based CM

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**Discharge Criteria**

**Discharge Date:** \_\_\_\_\_

A person on conditional release, probation, parole, in prison or hospitalized for less than one year cannot be discharged from a Category I case management service without prior permission of the UM Specialist.

Meets **one** of the following:

- 1.  Service no longer needed due to **all** of the following
  - a.  Functional stability has been maintained in the current community setting in the past 12 months
  - b.  In order to maintain current community stability, requires less than 1 time per month face-to-face contact with a similar service
- 2.  Consumer is in inpatient facility with expectation of stay to exceed 360 days.
- 3.  Consumer is in specialized treatment service that incorporates case management services.
- 4.  Consumer refuses case management services at this level.

**Additional Discharge Reasons:**

- Deceased
- Transfer to State Institution\*\*
- Moved from Hawaii
- Transfer to another AMHD Funded Program\*
- Closed – Unable to Locate / No Contact
- Other (Contact AMHD UM)

\* Includes change in LOC

\*\* Includes incarceration or long-term hospitalization

Discharged to (Provider): \_\_\_\_\_

Service Exclusions

- 1.  No other case management service would be appropriate while consumer is receiving this service.

Clinical Exclusions

- 1.  Consumers who require inpatient services or who are in specialized treatment services as a result of discharge from inpatient.
- 2.  Consumers who can maintain functioning with less intensive case management interventions or who show increased risk factors for harm or hospitalization would not be appropriate.

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Name of Consumer: \_\_\_\_\_ Community Based CM  
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**Justification for request despite exclusions:**

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Name and Title of Provider Representative Completing Form (Please Print):

Name \_\_\_\_\_ Title \_\_\_\_\_

Date Form Completed \_\_\_\_\_

Signature \_\_\_\_\_