

Consumer Name (PRINT): _____ CBI/CRF  Group A

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**COMMUNITY BASED INTERVENTION (CBI) WRAP AND NON-WRAP
AND CONSUMER RESOURCE FUND (CRF) AUTHORIZATION FORM**

THIS REQUEST MUST BE ACCOMPANIED BY A CURRENT LOCUS

PURPOSE

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

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 #: _____

PROVIDER CONTACT INFORMATION

Provider Agency: _____ Submitted by: _____

Provider Phone: _____ FAX: _____

Address: _____ City: _____ State: HI Zip: _____

Case Management Agency/Level of Care: _____

Case Manager: _____ Phone: _____

Use an X mark in the boxes as appropriate.

TYPE OF REQUEST: (please check one):

Community Based Intervention Non-Wrap (CBI) Wrap

Community Based Intervention Wrap (CBI)

Consumer Resource Fund (CRF)

Consumer updated Financial Information

Hours Requested: (Please Specify)

Number of hours _____ / day _____

Number of Days per week _____

Amount Requested: (Please specify)

\$ _____

Consumer Name (PRINT): _____

CBI/CRF



Group A

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CRF or CBI Non-Wrap requests:

1. Reason for request (rent, security deposit, etc.).

2. Reason consumer is unable to pay this expense.

3. Document all other resources where you attempted to obtain monies and the result of attempts.

4. Consumer's monthly income (amount/source).

5. Consumer itemized monthly expenses: (include all monthly expenses consumer will expect to pay in an average month).

Item	Expense

Consumer Name (PRINT): _____

CBI/CRF



Group A

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CBI Wrap requests:

1. Justification for number of hours:

2. Expected duties of Wrap provider:

3. Expected outcomes:

Use an X mark in the boxes as appropriate.

CBI Admission Criteria

Choose I or II of the following:

I. One-to-One Wrap

1. Meets all of the following:

- a. Identified specific self-care or self-regulating limitation which service will address;
- b. Measurable outcomes of how service will assist consumer is documented;
- c. No other community supports or resources available to provide this assistance;
- d. Reasonable likelihood that service will increase functioning or maintain stabilization.



II. Non-Wrap Services

1. Meets **all** of the following:

- a. Identified specific and documented psychiatric or medical need for which the service is requested;
- b. Measurable outcomes of how goods or service will assist consumer is documented;
- c. No other financial means of paying for the goods or service;
- d. No other community resource provides the goods or service.

CRF Admission Criteria

Meets **all** of the following:

- 1. Consumer is actively engaged in housing and/or vocational pursuits that are designed to increase recovery and independence;
- 2. Other funding sources have been contacted and the consumer does not qualify for assistance through the other agencies/programs;
- 3. The request is anticipated to be a one-time request and is not for maintenance of either housing or vocational on a long-term basis;
- 4. Request is included in the treatment plan and consumer is in agreement with the request.

CBI Continued Stay Criteria

Choose I or II of the following:

I. Wrap One-to-One

1. Meets **all** of the following:

- a. Continues to meet initial criteria;
- b. Identified specific self care or self regulating limitations continue to justify this service;
- c. Titration has been considered.

II. Non-Wrap Services: No continued stay.

CRF Continued Stay Criteria: *There is no continued stay. All requests are considered and reviewed as initial authorization requests.*

CBI Discharge Criteria

Choose I or II

I. Wrap One-to-One

1. Meets **one** of the following:

- a. Identified self-care or self-regulation has improved and this service is no longer needed.
- b. Consumer needs a higher level of care and the new services will provide similar assistance.

Consumer Name (PRINT): _____

CBI/CRF



Group A

II. Non-Wrap Services

a. Services/goods have been provided.

CRF Discharge Criteria

Discharge occurs after the service has been rendered.

CBI Service Exclusions:

- 1. Services would not be appropriate for consumers in inpatient setting.
- 2. Wrap One-to-One should not be used as a substitution for higher level of care services, such as inpatient or specialized residential.
- 3. Consumers receiving Peer Support services would not normally be authorized for One-to-One Wrap.

CRF Service Exclusions:

- 1. CRF Funds are not used for medication.
- 2. Personal assistance.
- 3. One-to-one wrap around services.

CBI and CRF Clinical Exclusions: No specific clinical exclusions.

Provide clinical justification for this expense if it is not listed in the acceptable criteria above:

Complete this section for Only CBI Non Wrap and CRF.

Name of Provider of Services: _____

Check Written To (If different from Name of Provider): _____

Mailing Address: _____

Consumer Name (PRINT): _____

CBI/CRF



Group A

CONSUMER NAME ON MEMO OF CHECK: YES NO

Submit the following documents with this request:

CBI Non-Wrap or CRF: Treatment Plan (The treatment plan must contain CBI/CRF as an intervention and indicate that the case manager will monitor the re-payment); LOCUS; Repayment Plan; and DOH Consent form allowing information to be shared with Egami & Ichikawa, CPAs.

CBI Wrap: Treatment Plan (The treatment plan must contain CBI Wrap as an intervention and include wrap duties as well as expected outcomes); LOCUS; and DOH Consent form allowing information to be shared with Egami & Ichikawa, CPAs.

Remember: Updates on the treatment plan must be signed and dated by the consumer and case manager.

Complete this section for all CBI/CRF requests:

Requested by: _____ Title: _____

Approved by CMHC Manager or Requestor's Supervisor: (PLEASE PRINT)

Signature of Supervisor: _____

Phone Number: _____ Date: _____

Attestation below for Group A Services Only.

I ATTEST THAT THE SERVICE REQUESTED IS CLINICALLY NECESSARY FOR THE ABOVE NAMED CONSUMER.

QMHP Name: (PLEASE PRINT) _____

License Type: _____ Date Submitted: _____

Phone: _____ FAX: _____

QMHP Signature: _____

COMMENTS (For AMHD UM use only)

Approved By: _____ Date : _____