

# (HLOC) Higher Level Of Care Auth Request Form - Fax: (724) 744-6329

**Requested Start Date for this Authorization:** \_\_\_/\_\_\_/\_\_\_

**Admit Date for this Level of Care:** \_\_\_/\_\_\_/\_\_\_

Level of Care:  LTSR  ACT/CTT/YACTT

Tx Unit/Program: \_\_\_\_\_

Type of Review:  Prospective  Concurrent

Type of Care:  mental Health

Precipitating Event: \_\_\_\_\_

Member's Current Location:  ER  Jail/Detention  Facility

Provider's Office  Home/Community  Other

**DEMOGRAPHICS:**

Member's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Member MA ID#: \_\_\_\_\_

Member's City/State: \_\_\_\_\_

Facility: \_\_\_\_\_ Facility ID: \_\_\_\_\_

Facility Address/City/State: \_\_\_\_\_

Attending MD: \_\_\_\_\_

Attending's Phone Number: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Contact Phone: \_\_\_\_\_ ContactFax: \_\_\_\_\_

**DSM-IV DIAGNOSIS:**

Axis I: 1.) \_\_\_\_\_ 2.) \_\_\_\_\_

Axis II: 1.) \_\_\_\_\_ 2.) \_\_\_\_\_

Axis III: 1.) \_\_\_\_\_ 2.) \_\_\_\_\_

Axis IV: 1.) \_\_\_\_\_

Axis V: Current GAF: \_\_\_\_\_ Highest GAF Previous Year: \_\_\_\_\_

Current Risks: Risk Level Scale: 0=None, 1=Mild, ideation only, 2=Moderate, ideation with EITHER plan or history of attempts, 3=Severe, ideation AND plan with either intent or means, NA=Not Assessed.

Circle risk level for each category and check all boxes that apply:

Risk to Self (SI): 0 1 2 3 NA - with  ideation  intent  plan  means

Risk to Others (HI): 0 1 2 3 NA - with  ideation  intent  plan  means

Current Serious Attempts:  Yes  No Circle: S I H I

Prior Serious Attempts:  Yes  No Circle: S I H I

Prior Serious Gestures:  Yes  No Circle: S I H I

Date of the Most Recent Attempt or Gesture: \_\_\_/\_\_\_/\_\_\_

**CURRENT IMPAIRMENTS:**

Scale: 0 Scale: 0=None, 1=Mild, 2=Moderate, 3= Severe, NA- Not Assessed

0 1 2 3 NA Mood Disturbance (Depression or Mania)

0 1 2 3 NA Anxiety

0 1 2 3 NA Psychosis

0 1 2 3 NA Thinking/Cognition/Memory

0 1 2 3 NA Impulsive/Reckless/Aggressive

0 1 2 3 NA Activities of Daily Living

0 1 2 3 NA Weight Loss Assoc. with Eating D/O

0 1 2 3 NA Medical/Physical Conditions(s)

0 1 2 3 NA Substance Abuse/Dependence

0 1 2 3 NA Job/School Performance

0 1 2 3 NA Social/Marital/Family Problems

0 1 2 3 NA Legal

**MENTAL HEALTH/PSYCHIATRIC TREATMENT HISTORY:**

(Please check all that apply)

**Outpatient** If "Outpatient", please indicate:

Outcome:  Unknown  Improved  No Change  Worse

Treatment Compliance (Non-Med):  Unknown  Poor  Fair  Good

**IOP/Partial** If "IOP/Partial", please indicate:

Outcome:  Unknown  Improved  No Change  Worse

Treatment Compliance (Non-Med):  Unknown  Poor  Fair  Good

**Inpatient/Residential/Group Home** If "Inpatient/Residential, please indicate:

Outcome:  Unknown  Improved  No Change  Worse

Treatment Compliance (Non-Med):  Unknown  Poor  Fair  Good

Number of psychiatric hospitalizations in the past 12 months: \_\_\_\_\_

Number of psychiatric hospitalizations in lifetime: \_\_\_\_\_

**SUBSTANCE ABUSE TREATMENT HISTORY:**  None  Unknown

(Please check all that apply)

**Outpatient** If "Outpatient", please indicate:

Outcome:  Unknown  Improved  No Change  Worse

Treatment Compliance (Non-Med):  Unknown  Poor  Fair  Good

**IOP/Partial** If "IOP/Partial", please indicate:

Outcome:  Unknown  Improved  No Change  Worse

Treatment Compliance (Non-Med):  Unknown  Poor  Fair  Good

**Inpatient/Residential** If "Inpatient/Residential", please indicate:

Outcome:  Unknown  Improved  No Change  Worse

Treatment Compliance (Non-Med):  Unknown  Poor  Fair  Good

Number of substance abuse hospitalizations in the past 12 months: \_\_\_\_\_

Number of substance abuse hospitalizations in lifetime: \_\_\_\_\_

**CO-OCCURRING DIAGNOSIS**  Yes  No

If yes, how is this being treated \_\_\_\_\_  
\_\_\_\_\_

**PSYCHOTROPIC MEDICATIONS:**

Current psychotropic meds?  Yes  No (If yes, please complete below.)

Medication	Dose	Frequency	Usually Adherent?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Is member engaged in treatment?  Yes  No

If no, why not? \_\_\_\_\_

**SUPPORT SYSTEMS:**

Who is it? \_\_\_\_\_

Are they involved in treatment?  Yes  No

Is family meeting/couples therapy indicated?  Yes  No Date \_\_\_\_\_

If no supports identified, what is the plan to increase prior to discharge?  
\_\_\_\_\_

What supports are being Explored: \_\_\_\_\_

**TREATMENT GOALS:**

1.) \_\_\_\_\_

2.) \_\_\_\_\_

3.) \_\_\_\_\_

**Report Treatment Goal Progress for continued stay.**

1.) \_\_\_\_\_

2.) \_\_\_\_\_

3.) \_\_\_\_\_

**Reason for Continued Stay:**  Stabilize Medications

Has Not Achieved Treatment Goals  Finalize Discharge Plan

Other \_\_\_\_\_

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**Barriers to Discharge:**  Discharge Treatment Setting Not Available

Transportation  Adequate Housing/Residence

Lack of Community Support  Treatment Non-Compliance

Other \_\_\_\_\_

**Baseline Functioning:**  Holds job  Asymptomatic

Manages Meds/Med Compliant  Functions Independently/ADLs Satisfactory

Abstinent  Other \_\_\_\_\_

**DISCHARGE PLAN:**

Expected Discharge Date, If Known: \_\_\_/\_\_\_/\_\_\_

**Planned D/C Level of Care:**  Outpatient  Partial  IOP/SOP

Group Home  Halfway House  Residential

Other \_\_\_\_\_

**Planned D/C Residence:**  Home ( Alone  With Others)

Nursing Home/Assisted Living  Group Home/Halfway House  Shelter

Correction Facility  Respite  State Hospital  Residential Placement

Transfer to Medical  Other \_\_\_\_\_

**Start date for Authorization:** \_\_\_\_\_

**Units:** \_\_\_\_\_

**Days Per Week** \_\_\_\_\_

**Hours Per Day** \_\_\_\_\_

**VBH-PA –HLOC**

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*By completing this box, you will assure that this page is linked to the first page should they become separated. Thank you.*

Member's Name: \_\_\_\_\_

Member's ID Number: \_\_\_\_\_

Member's Date of Birth: \_\_\_/\_\_\_/\_\_\_