Prior Authorization Request for Adult Behavioral Health Residential Facility Services (Short Term BHRF – H0018) and Adult Behavioral Health Therapeutic Homes (ABHTH)Fax # 844-424-3976

Do not leave lines blank. Please complete this form electronically, print and fax to **(844) 424-3976.**

Requested Type of BHRF ☐ABHTH ☐ 24 Basic ☐ Co Occurring ☐ PCS (Personal Care Services) ☐ Eating Disorder

Name: **DOB**:

AHCCCS #: **Gender:** Choose **Transgender:** Choose

Current status: ☐T19 ☐NT19 ☐SMI T19 ☐SMI NT19 ☐ Transitional youth

Treating Doctor/NP, Name and phone number

Email:

Date of last Psychiatric appointment:

Behavioral Health Diagnoses:

Medical Diagnoses:

Clinic Name: **Requesting CM name**:

Contact information for requestor: **email**:

Phone #: **Fax #:**

CC (Name and Email):

CD (Name and Email):

Current Outpatient Treatment Level: Select

Legal Guardian: ☐ Pub Fid

Who is making the request? ☐legal guardian ☐Member

Other involved parties: ☐PO ☐ DDD ☐ Advocate

Does member have special assistance: Choose Yes or No **Name and Email):**

Members Monthly Financial Income:

Payee? (Name & Phone Number):

Is Member on ☐: COT ☐ Probation

Provide information on legal history: (**sex offender/level, children or adults, felony charges**

Current location of member: (*i.e. inpatient, homeless, family etc..*)

How long at this location:

Attach the following documents: absence of these documents will delay decision of this request. (check each box of documentation provided)

☐ Psychiatric evaluation dated within past year

☐ Last 3 psychiatric progress notes from outpatient psychiatric provider & psychiatric notes from Inpatient Hospital

☐ Current Medication Sheet

☐ ISP/ assessment

☐ Staffing note that specifically discusses BHRF

☐ Medical documentation of recent care specific to any request for PCS.

☐ Any pertinent psychological/psychiatric testing or medical imaging reports.

☐ **Documentation of current substance diagnosis for any request for Co-occurring.**

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Reason for Referral: (check all that apply)

☐ Self-harming behaviors ☐ Physical aggression ☐Substance Use ☐significant impulsivity impedes safety ☐ Sexually maladaptive behavior ☐Inability to maintain safety despite environmental supports ☐inability/ neglect or disruption to maintain self-care ☐ inability to self-administer medications

☐ Other describe:

Provide examples for each item checked above: *including specific, detailed symptoms/duration/recent legal history/ charges / stressors/ complicating issues* ***within the last 2 months***:

Current psychiatric and therapeutic services utilized within the last 90 days*: with frequency of each/ dates of service provided and effect?* ***Please provide the last provider progress note for each service. (***do not include case management or RN services)

Reason for Service	Type of service	Exact Dates of services	Outcome

Current Functioning:

Please describe changes or serious impairment of behaviors over the ***past 3 months*** *caused by psychiatric symptoms which are not responding to the above services or prevent outpatient services from being implemented. Please specifically identify*:

Provide any historical learning, dementia, or developmental diagnosis (including IQ score):

Can member self-administer all medical and physical medications? Choose Yes or No
If No, what specific assistance do they need to self-administer their medications?

If Insulin dependent diabetes is the member able to give their own insulin: Choose Yes or No

Check any medical (assistive) devices the member uses:
☐Walker ☐Wheelchair ☐Oxygen ☐CPAP ☐Other:

Any active self-harm, DTS or DTO behaviors: Choose Yes or No **If yes describe:**

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Expected improvement from this level of care requested:

Behavior or symptoms requiring treatment	Goal level of functioning for discharge

Tentative Discharge Plan*: Aftercare plan to include recommendations from all members of team including treating BHMP,* plan *A and Plan B*. ***Included where will patient reside after d/c*** *from residential treatment and what treatment services will be provided***?**

Note: Please make sure that this application has been reviewed and the member/guardian is in agreement with short-term treatment in residential care and the requirement to plan for discharge when the member no longer meets medical necessity criteria to remain in residential treatment.

Member Name:

Treatment discussed with member and member agrees to BHRF treatment and step-down requirements?

Choose Yes or No

Name of Consenting Guardian:

Treatment discussed with guardian and guardian agrees with BHRF treatment and step-down requirements?

BHMP Name: **Signature:_____ Date:_____**

CD Name: **Signature:_____ Date: _____**

Name of person completing this form:

Members Preference for Geographical Location for BHRF if available.

East Valley Select **West Valley** Select

Central phoenix Select **North Phoenix** Select

South Phoenix Select