Member's Full Name: Medicaid #:

SERVICE AUTHORIZATION FORM

THERAPEUTIC DAY TREATMENT (TDT) H2016 INITIAL Service Authorization Request Form

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name:		Organization Name:	
Member Last Name:		Group NPI #:	
Medicaid #:		Provider Tax ID #:	
Member Date of Birth:		Provider Phone:	
Gender:	☐ Male ☐ Female ☐ Other	Provider E-Mail:	
Member Plan ID #:		Provider Address:	
Member Address:		City, State, ZIP:	
City, State, ZIP:		Provider Fax:	
Parent/Guardian:		Clinical Contact Name & Credentials*:	
Parent/Guardian Contact Information:		Clinical Contact Phone:	
		* *This is the individual to whom the MCO can reach out to answer additional clinical questions.*	

Procedure Code: ☐ H2016 (school day) ☐ H2016 – UG (after-school) ☐ H2016 – U7 (summer)	
Provide the name of the school (and/or other setting) where these services are being provided:	
Request for Approval of Services: **Retro Review Request?** ☐ Yes ☐ No From _____ (date), To _____ (date), for a total of _____ units of service. Plan to provide _____ hours of service per week.	
Is this a new service for the member? ☐ Yes ☐ No (If no, then complete an authorization for continuing care.)	
Primary ICD-10 Diagnosis	
Secondary Diagnosis	

Name of Medication	Dosage	Frequency
If additional medications are prescribed, include listing of medications, dosage, and frequency in the Notes section.		

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SECTION I: THERAPEUTIC DAY TREATMENT ELIGIBILITY CRITERIA

Individuals shall demonstrate medical necessity for the service arising from a condition due to mental, behavioral or emotional illness resulting in significant functional impairments in major life activities.

Individual must meet <u>TWO</u> of the following on a continuing or intermittent basis; check applicable criteria:

Has difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out of home placement because of conflicts with family or community (Note: Please refer to DMAS provider manual for risk of hospitalization and out of home placement definitions/criteria).

☐ Yes ☐ No

**** If a child is at risk of hospitalization or an out of home placement, state the specific reason and what the out-of-home placement may be.***

Describe current symptoms and behaviors or other pertinent information which provides substantiation for CHECKED response (Identify frequency, intensity, and duration of each behavior):

- **Does the individual have an IEP? ☐ Yes ☐ No**
- **# of days unexcused absences in the school year:**
- **# of days of in-school suspensions in the past 6 months:**
- **# of days out of school suspensions in the past 6 months:**
- **# of classes taking and how many are passing grades:**

Exhibits such inappropriate behavior that documented, repeated interventions by the mental health, social services or judicial system are or have been necessary.

☐ Yes ☐ No

Describe current and past services/interventions which provides substantiation for CHECKED response as stated above:

Provider	Currently in Service?	Dates of Services/ Interventions	Outcomes/Current Progress
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		

Exhibits difficulty in cognitive ability such that they are unable to recognize personal danger or significantly inappropriate social behavior.

☐ Yes ☐ No

Describe current symptoms and behaviors or other pertinent information which provides substantiation for CHECKED response (Identify frequency, intensity, and duration of each behavior):

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Individual must meet ONE of the following; check applicable criteria:	
The individual must require year-round treatment to sustain behavior or emotional gains **Describe pertinent information which provides substantiation for CHECKED response (ex. What services have been tried and with what result, Describe severity and intensity of behaviors):**	☐ Yes ☐ No
The individual's behavior and emotional problems are so severe that they cannot be handled in a self-contained or resource emotionally disturbed (ED) classroom without: **a. TDT programming during the school day or** **b. TDT programming to supplement the school day or school year** **Describe pertinent information which provides substantiation for CHECKED response:**	☐ Yes ☐ No
The individual would otherwise be placed on homebound instruction because of severe emotional/behavioral problems that interfere with learning. **Describe pertinent information which provides substantiation for CHECKED response:**	☐ Yes ☐ No
The individual must have deficits in social skills, peer relations or dealing with authority, are hyperactive, have poor impulse control, are extremely depressed or marginally connected with reality. **Describe pertinent information which provides substantiation for CHECKED response:**	☐ Yes ☐ No
The individual is placed or pending placement in a preschool enrichment and or early intervention program but the individuals emotional/behavioral problems are so severe that it is documented that they cannot function or be admitted to these programs without TDT services. **Describe pertinent information which provides substantiation for CHECKED response:**	☐ Yes ☐ No

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SECTION II: CARE COORDINATION		
Primary Care Physician:		
Other medical/behavioral health concerns (including substance abuse issues, personality disorders, cognitive impairments) that could impact services? ☐ Yes ☐ No (If yes, explain below.)		
Please indicate other current medical/behavioral services and additional community supports and interventions being received:		
Name of service/treatment	Provider/Contact Information	Frequency
Indicate plan to coordinate with primary care physician and other treatment providers/services to help ensure treatment interventions are coordinated:		

SECTION III: TRAUMA-INFORMED CARE	
Trauma-Informed Care (Many individuals have experienced potentially traumatic events in their lifetime. It is important that everyone is aware of the potential impact of trauma on those they serve, prepare to recognize and offer trauma-specific services when needed, and be mindful of trauma-informed interventions.)	
Is there evidence to suggest this member has experienced trauma?	☐ Yes ☐ No
What is your plan to assess/refer and address the current and potential effects of that trauma?	

SECTION IV: INDIVIDUAL TREATMENT GOALS
Treatment Goals/Progress: • Describe person-centered, recovery-oriented, trauma-informed mental health treatment goals as they relate to requested treatment. Include individual strengths/barriers/gaps in service, and written in own words of individual seeking treatment/or in a manner that is understood by individual seeking treatment. If individual has identified a history of trauma, please include trauma-informed care interventions in the treatment plan. • Services are intended to include goal directed training/interventions that will enable individuals to learn the skills necessary to achieve or maintain stability in the least restrictive environment. Providers should demonstrate efforts to assist the individual in progressing toward goals to achieve their maximum potential. • Please demonstrate that the individual is benefiting from the service as evidenced by objective progress toward goals or modifications and updates that are being made to the treatment plan to address areas with lack of progress. • Include appointments and medications adherence issues and plans to address this, if applicable.
Resources and Strengths: Document individual's strengths, preferences, extracurricular/community/social activities and people the individual identifies as supports.
Please describe any barriers to treatment:

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Please describe how coordination of TDT services will occur with school personnel and identified family member(s) involved in individual's care on a daily/weekly basis (i.e. treatment meetings, progress reports, correspondence with family, etc.):
Goal/Objective (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):
How many days per week will be spent addressing this goal on average?
What specific counseling and/or behavioral interventions will be provided to address this goal?
How many hours per week of onsite supervision or direct counseling/therapy by an LMHP Type will be provided?
If no in-school counseling/therapy is provided, why, and who is providing therapy/counseling and what is the frequency?
Goal/Objective (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):
How many days per week will be spent addressing this goal on average?
What specific counseling and/or behavioral interventions will be provided to address this goal?
How many hours per week of onsite supervision or direct counseling/therapy by an LMHP Type will be provided?

If no in-school counseling/therapy is provided, why, and who is providing therapy/counseling and what is the frequency?
Goal/Objective (Please provide objective measures to demonstrate evidence of progress. Measurable objectives should have meaningful tracking values; avoid percentages unless able to track and measure percent completion i.e. if 80%, state 8 of 10 as a more trackable value):
How many days per week will be spent addressing this goal on average?
What specific counseling and/or behavioral interventions will be provided to address this goal?
How many hours per week of onsite supervision or direct counseling/therapy by an LMHP Type will be provided?
If no in-school counseling/therapy is provided, why, and who is providing therapy/counseling and what is the frequency?

SECTION V: DISCHARGE PLANNING		
DISCHARGE PLAN (Identify lower levels of care, natural supports, warm-hand off, care coordination needs)		
Step Down Service/Supports	Identified Provider/Supports	Plan to assist in transition
Recommended level of care at discharge:		
Estimated date of discharge:		

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The appropriate assessment or addendum has been completed by an LMHP, LMHP-R, LMHP-S, or LMHP-RP and the individual's psychiatric history information reviewed. By my signature (below) I am attesting that the individual meets the medical necessity criteria for the identified service. The assessment or applicable addendum for this service was completed on .

Signature (actual or electronic) of LMHP (Or R/S/RP): _____

Printed Name of LMHP (Or R/S/RP):_____

Credentials & NPI: _____

Date: _____

If any additional CMHRS services were recommended by the assessment or addendum referenced above, please identify the services here:

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NOTES SECTION
If needed, use this page for any answer too long to fit within the form's provided spaces. Please note which section you are continuing before each answer.