UnitedHealthcare Community Plan

UnitedHealthcare Children's Rehabilitative Services (CRS) Out-of-Home Request

To request authorization for covered Medicaid services provided in a member's group home or facility, please fax this form with a completed prior authorization form to 888-899-1499.

Member Name:	**Member Date of Birth:**
CRS ID#:	**AHCCCS ID#:**

Members of Child Family Team(CFT)/Adult Recovery Team (ART): *(double click to mark appropriate box)*

☐ DCS
☐ JPO
☐ DDD
☐ Other (list names of additional attendess):

Treating Doctor/NP Name:	**Phone Number:**
Behavioral Health Agency:	**Requesting Clinician/Title:**
Phone Number:	**Email Address of Requesting Clinician:**

Responsible Party: *(double click to mark appropriate box)*

☐ Parent *(Name and Phone Number):*
☐ DCS/Case Worker *(Name and Phone Number):*
☐ Legal Guardian *(Name and Phone Number):*
☐ Other:

Requested Level of Care: *(double click to mark appropriate box)* ☐ RTC ☐ BHRF ☐ HCTC

Urgent Request? *If urgent, please explain the health and safety risk to expedite a clinical decision to a three business days. All supporting documentation will need to be included within 24 hours of an urgent request.*

☐ Yes ☐ No If yes, explain (required):

Current Location of Member: *(e.g., inpatient or foster care family)*:

How Long at this Location? *If request is for higher level of care, please provide current services/ safety plan.*

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Clinical Summary and Rational for Request from CFT: *include specific, detailed symptoms, duration, legal history, changes, stressors and complicating issues within the last three months.*

Diagnoses: *Include substance use/abuse/dependence. Please be detailed, including developmentally disability if applicable.*

Primary CRS Diagnosis:

Behavioral and/or Medical Diagnoses: *Please include care providers seen, next appointments, pending procedures, ADL issues, medical equipment/orthotics and unusual medications.*

Current Psychiatric and Therapeutic Services: *List frequency of each symptom.*

Target Symptoms	Type of Service	Exact Dates of Service	Effect

Prior Services Provided with Desired Impact/Actual Impact/Compliance: *Within the past 90 days and any earlier levels of care.*

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1. Risk of Harm: *What are the behaviors in the past 30-90 days that require placement?*

2. Functioning: *Please describe in detail any serious functioning impairment directly caused by psychiatric symptoms that persists in the absence of stressors and impairs recovery.*

3. Expected Improvement: *Give clear and specific goals for placement and describe how this patient will be able to meet these goals given any baseline issues for this patient, such as cognitive disabilities. What will be expected functioning ability at the time of discharge from residential treatment?*

Treatment need/current functioning	Goal level of functioning for discharge

4. Discharge Plan: *Provide an aftercare plan that includes recommendation from all team members including treating behavioral health provider. Please state specific goals/likely target symptoms. Provide a detailed plan for discharge goals for the member from residential treatment, Plan A, Plan B, and Plan C.*

Plan A

Target Symptoms	Best Practice Treatment	Frequency

Where will the patient reside after discharge from residential treatment? What treatment will be provided?

Plan B

Target Symptoms	Best Practice Treatment	Frequency

Where will the patient reside after discharge from residential treatment? What treatment will be provided?

Plan C

Target Symptoms	Best Practice Treatment	Frequency

Where will patient reside after discharge from residential treatment? What treatment will be provided?

Please Provide a Copy of the following Documentation, if available

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Child and Adolescent Intensity Instrument (CASII) (Ages 6 – 18): ☐ Yes/Score/ Date: ☐ No

Psychological Evaluation Summary: ☐ Yes/Date: ☐ No

Individualized Education Program (IEP): ☐ Yes/Date: ☐ No

Neuropsychological Evaluation: ☐ Yes/Date: ☐ No

Functional Behavioral Assessment: ☐ Yes/Date: ☐ No

Medical Specialty Providers involved with the CRS care or MSIC following Member		
Provider Name	**Specialty**	**Phone Number**

Requesting Clinician Name:	**Signature/Date:**
Supervisor Name:	**Signature/Date:**

Current Psychiatric and Medical Medication List with Dosages and Effect			
Medication	**Dose/Route**	**Target Symptoms**	**Effect/Duration of Trial/Compliance**

The following must be completed by a psychiatric provider, or by a medical director if not assigned or if assigned provider is not available

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Detailed Clinical Summary From Treating Psychiatric Provider for Past Year:	
Clinical Opinion and Rationale (Based on Level of Care Criteria) of Psychiatric Provider for Placement Request:	
Printed Name of Provider:	**Signature/Date:**