SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

MANAGED CARE CONTINUED AUTHORIZATION REQUEST

Confidential Patient Information: See California Welfare and Institutions Code Section 5328

CLIENT NAME_____**MH#**_____**DOB**_____

PROVIDER NAME_____**PROVIDER TELEPHONE**: _____

DATE OF REQUEST: _____ **COUNTY CLINIC IF ANY**: _____

ASSESSMENT UPDATE

This form must be completed and submitted prior to utilizing all authorized services and/or prior to expiration of authorization. Submitting at least two weeks in advance will prevent any gaps in service as all services must be preauthorized.

CURRENT FUNCTIONING: *If client meets medical necessity, must check at least one risk factor*

☐ Current ☐Recent decrease in functioning on a life area due to primary diagnosis
☐ Current difficulty maintaining employment/schooling/living situation due to mental health symptoms
☐ On-going mental health symptoms related to primary diagnosis needing treatment
☐ Current ☐Recent risk -of harm to others (threats, significant ideations, violent acts)
☐ Current ☐Recent risk -of harm to self (threats, significant ideations, attempts, plans)
☐ Current ☐Recent risk -hallucinations, bizarre behavior, or delusional thoughts
☐ Current ☐Recent risk- gravely disabled (unable to perform most daily tasks)
☐ Current ☐Recent risk- Health is at significant risk due to mental health symptoms
☐ Current ☐Recent Psychiatric hospitalization within the last 6 months

Note: Some of the above risk factors may indicate the need for a higher level of care. If so determined, please contact Call Center staff at 1-800-686-0101.

CURRENT FUNCTIONAL IMPAIRMENTS:

☐School/Work Functioning ☐Social Relationships ☐Daily Living Skills

☐Ability to Maintain Placement ☐Symptom Management

INITIAL ASSESSMENT DATE: _____

(Date the Initial Assessment & Tx Plan was completed, must be updated every three years)

CURRENT SYMPTOMS RELATED TO DIAGNOSIS:

Fax to 650-596-8065 or mail to Access Call Center – 310 Harbor Blvd., Bldg. E, Belmont, CA 94002

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PROGRESS MADE SINCE LAST ASSESSMENT:

MENTAL HEALTH DIAGNOSIS

Based on client's presentation at the time of assessment; focus of clinical attention or treatment.

DSM 5 Diagnosis:	ICD - 10
Primary:	
Secondary:	

TREATMENT AUTHORIZATION REQUEST:

CPT Code:	Bilingual Differential Yes/No	Number of Services	Frequency	Authorization Begin Date

Provider Signature:_____ **License No:** _____ **Date** _____

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CLIENT TREATMENT AND RECOVERY PLAN

PLAN START DATE | | **PLAN END DATE (1 yr.max)** | |

CLIENT'S OVERALL GOAL/DESIRED OUTCOME: *What the client wants from treatment, in client's words.*

DIAGNOSIS/PROBLEMS/IMPAIRMENTS – Signs, symptoms and behavioral problems resulting from the diagnosis that impede client from achieving desired outcome. Impairments related to the diagnosis must be addressed in all **medical necessity** goals.

GOAL - Development of new skills/behaviors and reduction, stabilization, or removal of symptoms/impairments.
Indicate whether this is a **New Goal:** ☐ **Continuing Goal:** ☐

OBJECTIVES - Client's next steps to achieving goal. Must be **observable, measurable and time-limited** objectives that address **symptoms/impairments** linked to the **primary diagnosis**.

INTERVENTIONS – Describe in detail the interventions proposed for <u>each service type</u>: Individual Therapy, Family Therapy Medication Support…etc. (E.g. – Clinician will provide individual therapy, utilizing cognitive-behavioral techniques, to assist client with decreasing his depressive symptoms.)

Client Signature:_____**Date**_____

Parent/Guardian Signature:_____**Date**_____

Provider Signature: _____ **License No.**_____**Date** _____

Copy offered to client/accepted:☐ Copy offered/declined:☐ Unable to offer Copy-See prog. note dated:_____