

WHN – Western Highlands Network – Treatment Authorization

Patient's Name: _____

Social Security #: _____ D.O.B: _____

Current Address: _____

City/State/Zip: _____

Medicaid #: - - - None County (Medicaid Eligibility): _____

Attending Provider: _____

Legal Guardian: None Parent DSS Other: _____ Name: _____

DIAGNOSES: Indicate Primary Diagnosis with (P)
 Axis I: _____

 Axis II: _____
 Axis III: (Medical Diagnosis (es)): _____
 Axis IV: _____
 GAF: _____

DATE OF INITIAL ASSESSMENT and/or Subsequent Assessments prior to referral: _____

Client Specialty: MH SA DD Treatment: Voluntary Involuntary

Request Type: Initial Request Reauthorization Discharge ***Expedited***

(See attached form for Dimension scoring instructions)

LOCUS		1	2	3	4	5	COMPOSITE SCORE	LOC RECOMMENDATION		
I. Risk of harm		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
II. Functional Status		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
III. Co-Morbidity		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
IV-a. Recovery Environment (support)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
IV-b. Recovery Environment (stress)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
V. Treatment And Recovery History		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
VI. Engagement		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
CALOCUS		1	2	3	4	5	COMPOSITE SCORE	LOC RECOMMENDATION		
I. Risk of harm		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
II. Functional Status		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
III. Co-Morbidity		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
IV-a. Recovery Environment (support)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
IV-b. Recovery Environment (stress)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
V. Resiliency and Treatment History		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
VI-a. Acceptance/Engagement (C&Y)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
VI-b. Acceptance/Engagement (Parent/PS)		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

COMMENTS: _____

ASAM Patient Placement Criteria ~ Adult/Adolescent (See ASAM criteria for placement considerations)

	I	II.1/5	III.1	III.3	III.5	III.7	IV
I. Withdrawal/Intoxication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
II. Medical Complication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
III. Behavioral/Emotional Cognitive Complication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV. Readiness for Change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
V. Relapse/Continued use or problem potential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
VI. Recovery Environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Placement Recommendation:							

CURRENT (C) and Previous (P) TREATMENT

Service	Current	Previous	Comments
Case Management	C	P	
Mental Health Outpatient	C	P	
Mental Health Inpatient	<input type="checkbox"/> C	<input type="checkbox"/> P	
Substance Abuse Outpatient	C	P	
Detox	<input type="checkbox"/> C	<input type="checkbox"/> P	
Substance Abuse Inpatient	C	P	
Other	<input type="checkbox"/> C	<input type="checkbox"/> P	

SUBSTANCE USE

Drug of Choice	N/A	Age of 1 st Use	Route of Usage	Frequency	Amount	Date of Last Use
Primary:		Years			Per	
Secondary:		Years			Per	
Tertiary:		Years			Per	
Other:		Years			Per	

MEDICAL: Current Primary Care Physician Name: _____ Medically - <input type="checkbox"/> Compliant <input type="checkbox"/> Non-compliant <input type="checkbox"/> Comments:			Signed Release to Primary Care Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Current Medications	Current Regimen	# of months		Current Medications	Current Regimen	# of months
mg		<input type="checkbox"/> <1 <input type="checkbox"/> >1		mg		<input type="checkbox"/> <1 <input type="checkbox"/> >1
mg		<input type="checkbox"/> <1 <input type="checkbox"/> >1				<input type="checkbox"/> <1 <input type="checkbox"/> >1
mg		<input type="checkbox"/> <1 <input type="checkbox"/> >1		Other:		<input type="checkbox"/> <1 <input type="checkbox"/> >1

Allergies: _____

<input type="checkbox"/> There is an Axis I or II MH/SA diagnosis (other than sole diagnosis of I/DD) and is pregnant. <p style="text-align: center;">OR</p> <input type="checkbox"/> There is an Axis I or II MH/SA diagnosis (other than sole diagnosis of I/DD) <p style="text-align: center;">AND</p> <input type="checkbox"/> Requires coordination between two or more agencies including medical or non-medical providers <p style="text-align: center;">AND</p> <input type="checkbox"/> The recipient is unable to manage symptoms or maintain abstinence (independently or with family/caregiver support) due to at least <u>three</u> basic needs in the appropriate documented domains (housing, food, legal, educational, vocational, healthcare, transportation for necessary services). <p style="text-align: center;">OR</p> <input type="checkbox"/> The recipient is a child in a residential setting and needs coordination to transition to an alternate level of care <p style="text-align: center;">OR</p> <input type="checkbox"/> The recipient has experienced two or more crisis episodes requiring intervention through the emergency department, mobile crisis management, Facility Based Crisis, Hospitalizations, detoxification services in the last <u>three months</u> <p style="text-align: center;">AND</p> <input type="checkbox"/> Level of Care criteria is met (LOCUS/CALOCUS, ASAM, SIS) <p style="text-align: center;">AND</p> <input type="checkbox"/> Needs can not be met by lower level services	<input type="checkbox"/> There is an Axis II diagnosis present or the person has a condition that may be identified as comparable to an Intellectual and/or other Developmental Disability. <p style="text-align: center;">AND</p> <input type="checkbox"/> The recipient is experiencing difficulties in at least one of the following areas: <ol style="list-style-type: none"> 1. Is at risk for institutionalization, or hospitalization or is placed outside the natural living environment. 2. Is receiving or needs crisis intervention services, intensive in home services 3. Has unmet identified needs from multiple agencies. 4. Needs advocacy and service coordination to direct service provisions from multiple agencies. 5. DSS has substantiated abuse, neglect, or has established dependency. 6. Presenting with intense, verbal and limited physical aggression due to symptoms associated with diagnosis, which is sufficient to create functional problems in the home, community, school, job etc. <input type="checkbox"/> Level of Care criteria is met (LOCUS/CALOCUS/ASAM/SIS)
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Reason for Admission, Continued Stay or other comments: _____

Request for Service								
Service Description & Code	Funding Source	Frequency	Duration	Start Date	End Date	Provider	UM Action	Units Approved

Clinician Signature: _____	Requesting Provider: _____	Date: _____
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WHN Utilization Management Use Only

UM COMMENTS: _____

Utilization Management Care Coordinator: _____	Date: _____
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Western Highlands Network Utilization Management ACCESS#: Main#: Fax#:

Submission does not automatically constitute authorizations. All Treatment is subject to medical necessity determination and based on beneficiary eligibility