Utilization Management
PO Box 3378
Honolulu, Hawaii 96801-3378
Phone: 453-6904, 453-6981
Fax: 453-6995

Service Authorization Request

Housing 24 **Hour Group Home**

All fields are **mandatory.** UM may send back requests that are inaccurate or missing fields. The provider may not add additional fields, categories or otherwise amend this form in any way. Requests for authorization must be submitted to UM within thirty (30) days of the provision of service.

Consumer Information

Name(Last Name, First Name, Middle Initial) : _____

Date of Birth: _____ SSN: _____ Phone: _____

Is this Consumer Homeless: Yes ☐ No ☐ Is this Consumer a Veteran: Yes ☐ No ☐

Diagnostic Information

ICD 10 Code: _____ ICD 10 Code: _____

ICD 10 Code:_____ ICD 10 Code: _____

A minimum of **one** AMHD eligible ICD-10 code is necessary for authorization.

Case Manager Information

CBCM Agency: _____ Name of Case Manager: _____

Case Manager's Phone: _____ Case Manager's Fax: _____

All Housing services require linkage with case management.

Provider Information

Agency: _____ Submitted by: _____

Phone: _____ Fax: _____ Date of Submission: _____

Signature of staff submitting request: _____

Housing Site Information

Address: _____ City: _____

State: _____ Zip Code: _____

Note the site information must correspond with the specific site that is contracted with AMHD.

Authorization Information

Admit ☐ Date: _____ Cont. ☐ Date: _____ Discharge ☐ Date: _____

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AMHD
ADULT MENTAL HEALTH DIVISION

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Authorization Information Continued

Admission Criteria: (Must Meet all of the following)

	Risk Factors are manageable at this level of housing
	Does not meet criteria for a higher level of care (e.g , SRSP, TLP, ARCH, E-ARCH, ICF, SNF)
	Presents a reduction in ability to function such as performing personal hygiene and bodily care activities, obtaining adequate nutrition, sleep or becoming socially isolated

Continuation Criteria: (Must meet one of the following)

	Intensity of service being delivered continues to meet admission criteria: If this is selected the request must be accompanied by a current treatment plan
	Complications arising from initiation of, or change in, medication or other treatment modalities: If this is selected the request must be accompanied by clinical documentation of the change in medication of other treatment modalities
	Forensically Encumbered (Conditional Release, Released on Conditions, Mental Health Court, and Jail Diversion) If this is selected the request must be accompanied by the court order specifying level of care or location
	Consumer is experiencing symptoms of such intensity that admission to a higher level of care would likely occur upon discharge. If this is selected the request must be accompanied by clinical documentation of presenting symptoms requiring continued care

Discharge Criteria:

Deceased		Unable to locate		Requires Higher LOC		Hospitalization	
Clinically Ready For Discharge		Refuses Treatment		Incarceration		Moved from State/County	
Other Discharge Criteria (please specify):							
Discharge to:							

Consumer Name (Last Name, First Name, Middle Initial) :