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

AMHD
ADULT MENTAL HEALTH DIVISION

Service Authorization Request

Housing Semi-Independent

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 contract with AMHD.

Authorization Information

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

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Authorization Information Continued

Admission Criteria: (Must Meet **all** of the following)	
☐	Has the ability to function and live independently with minimal supervision.
☐	Does not meet criteria for a higher level of care (e.g. 8-16 GH, 24 HR GH, SRSP, TLP, ARCH, E-ARCH, SNF)
☐	Risk Factors are manageable at this level of housing

Continuation Criteria: (Must meet **two** 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
☐	Currently on the waitlist for Bridge Subsidy, Section 8, or Public Housing.

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) :