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	Supported Employment

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: _____ Reference 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.

Provider Information

Supported Employment Agency: _____ Submitted by: _____

Phone: _____ Fax: _____ Date of Submission: _____

Signature of staff submitting request: _____

CBCM Agency: _____ Case Manager & Phone: _____

Authorization Information

Admit ☐ Date: _____ Continued Stay ☐ Date: _____ Discharge ☐ Date: _____

Admission Criteria: (Must meet all of the following)	
☐	Consumer is employed (ideally in an integrated work setting) and wages are consistent with the current State of Hawaii minimum wage standard.
☐	Consumer requires follow-along support to maintain employment or transfer to a new one.
☐	Willing to participate in job development services, including on-the-job training and skills acquisition

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Continuation Criteria: (Must meet all of the following)	
☐	Consumer is employed ideally in an integrated work setting and wages are consistent with the current State of Hawaii minimum wage standard.
☐	Consumer is not yet able to maintain competitive employment without follow-along supports to maintain employment.
☐	Willing to participate in job development services, including on-the-job training and skills acquisition
☐	Participates in reassessment and alteration of strategies, as appropriate

Discharge Criteria: (Select one of the following)			
☐ Consumer has been competitively employed for more than 365 days	☐ Requires higher LOC	☐ Hospitalization	☐ Incarceration
☐ Consumer achieved maximum benefit from this service	☐ Unable to locate	☐ Refused services	☐ Moved from State/County
☐ Deceased	☐ Other Discharge Criteria (please specify):		

I ATTEST THAT THE SERVICE REQUESTED IS MEDICALLY APPROPRIATE FOR THE ABOVE NAMED CONSUMER.

QMHP Name: (Please Print)	License Type:
Signature:	Date:

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