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

Service Authorization Request

Peer Support Services

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) :			
Alias:	Sex:	Male ☐	Female ☐
Homeless: Yes ☐ No ☐	Veteran: Yes ☐ No ☐	Encumbered: Yes ☐ No ☐	

The following are legal encumbrances recognized by AMHD: Conditional Release (CR), Released on Conditions (ROC), Mental Health Court, and Jail Diversion.

Insurance information

If other coverage is available, this authorization is not effective or binding for the Adult Mental Health Division. **CCS members are ineligible for AMHD Peer Support Services.**

Type of insurance:	QI ☐	SLIMB ☐	Non-Pay ☐	VA ☐	Uninsured ☐	Other ☐

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

In order to receive support services such as Peer Support Services a consumer must be linked with Case Management, Homeless outreach **is not** considered case management.

CBCM Agency:	Name of Case Manager:
Case Manager's Phone:	Case Manager's Fax:

Provider Information

Agency:	Submitted by:	
Phone:	Fax:	Date of Submission:

Attestation

I attest that the service requested is clinically necessary for the above named consumer. I have reviewed and approved the information in the service authorization request.

QMHP Name: (Please Print)	
License type:	Date Signed:
Signature:	

Authorization Information

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

AMHD
ADULT MENTAL HEALTH DIVISION

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Authorization Information Continued

Admission Criteria: (Must meet **two** of the following)	
☐	Has an AMHD eligible diagnosis that indicates a significant impairment in functioning as evidenced by: inability to adhere with treatment/recovery, frequent use of crisis services, significant co-morbidity, involvement with the criminal justice system, troubled significant relationships, and neglect or avoidance on ability to fulfill social or vocational activities.
☐	Consumer is forensically encumbered (Conditional Release, Released on Conditions, Mental Health Court, and Jail Diversion).
☐	Consumer could benefit from informational, instrumental, and affiliational support to reduce current symptoms/behaviors, increase skills/abilities, and access to community resources.

Continuation Criteria: (Must meet one of the following)	
☐	Intensity of service being delivered continues to meet admission criteria
☐	Complications arising from initiation of, or change in, medication or other treatment modalities
☐	Forensically Encumbered (Conditional Release, Released on Conditions, Mental Health Court, and Jail Diversion)
☐	Consumer is experiencing symptoms of such intensity that admission to a higher level of care would likely occur upon discharge.

Discharge Criteria:

A consumer on Conditional Release (CR) Released on conditions (ROC), Jail Diversion or Mental Health Court **may not be discharged** without prior permission of the forensic Coordinator.

Deceased	☐	Unable to locate	☐	Requires Higher LOC	☐	Hospitalization	☐
Clinically Ready For Discharge	☐	Refuses Treatment	☐	Incarceration	☐	Moved from State/County	☐
Linked with CCS	☐	Other Payor	☐	No longer encumbered	☐	Long-term care	☐

Other Discharge Criteria (please specify):

Discharge to:

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