



Utilization Management

PO Box 3378 Honolulu, Hawaii 96801-3378
Phone: 453-6949 Fax: 453-6995

Service Authorization Request	LICENSED CRISIS RESIDENTIAL SHELTER
--------------------------------------	--

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:

Insurance Information

<input type="checkbox"/> Insured <u>If insured complete below</u>			<input type="checkbox"/> Uninsured <u>If uninsured skip to Diagnostic information.</u>			
Is Consumer a OHANA CCS Member <input type="checkbox"/> Yes <input type="checkbox"/> No <u>CCS members are not eligible for a LCRS Treatment Authorization</u>						
Health Plan:	United <input type="checkbox"/>	OHANA <input type="checkbox"/>	AlohaCare <input type="checkbox"/>	Kaiser <input type="checkbox"/>	UNITED <input type="checkbox"/>	Policy #:

Diagnostic Information

ICD 10 Code:	ICD 10 Code:
ICD 10 Code:	ICD 10 Code:

Case Manager Information

<input type="checkbox"/> CCS <input type="checkbox"/> AMHD CBCM <input type="checkbox"/> CMHC <input type="checkbox"/> CMO <input type="checkbox"/> None	Name of CM:
Case Manager's Phone:	Case Manager's Fax:

Provider Information

Agency: <input type="checkbox"/> CARE EH <input type="checkbox"/> CARE Oahu <input type="checkbox"/> Aloha House	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

<input type="checkbox"/> Continuation Request	Continuation start date	<input type="checkbox"/> Discharge Request	Discharge date
--	-------------------------	---	----------------



Utilization Management

PO Box 3378 Honolulu, Hawaii 96801-3378
Phone: 453-6949 Fax: 453-6995

Service Authorization Request	LICENSED CRISIS RESIDENTIAL SHELTER
--------------------------------------	-------------------------------------

Authorization Information Continued

Authorization Number	<u>Request will be returned if this field is not completed accurately.</u>
Continuation Criteria: (Must meet one of the following)	
	Patient continues to present with a level of risk related to harm towards themselves through suicide, self-injury, irritability or mania or to others through aggression, assaultive or homicidal behavior.
	Patient continues to present with disruptive mood, disordered thinking, disorientation, or other mental status changes that require LCRS level of care.
	Complications arising from the initiation of, or change in, medications or other treatment modalities exists.
	Effective planning for transition to a less restrictive level of care has begun and additional time in treatment days will reduce the probability of a re-admission to a more restrictive level of care.

Identified Level of care for Placement Note lack of housing in and of itself is **not** a justification for LCRS level of care.

SRSP	TLP	ARCH	ICF	SNF
24 Hour Group Home	8-16 Group Home	Semi-Independent	With Family	Independent
Other	Describe other placement:			

List Referrals made

Date of referral	Agency	Outcome

Discharge Reasons

Deceased	Refuses Treatment	Requires Higher LOC	Hospitalization	
Elopes	Crisis is Resolved	Incarceration	Moved from State/County	
Other Discharge Criteria (please specify):				
Discharge to:				

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



Utilization Management

PO Box 3378 Honolulu, Hawaii 96801-3378

Phone: 453-6949 Fax: 453-6995

Service Authorization Request

LICENSED CRISIS RESIDENTIAL SHELTER

WHODAS

WHODAS	In the past 30 days how much difficulty did you have in:									
	None		Mild		Moderate		Severe		Extreme or cannot do	
Standing for long periods such as 30 minutes?	1		2		3		4		5	
Taking care of your household responsibilities?	1		2		3		4		5	
Learning a new task, for example learning how to get to a new place?	1		2		3		4		5	
Joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	1		2		3		4		5	
In the past 30 days how much difficulty did you have in:										
How much have you been emotionally affected by your health problems?	1		2		3		4		5	
Concentrating on doing something for ten minutes?	1		2		3		4		5	
Walking a long distance such as a kilometer [or equivalent]?	1		2		3		4		5	
Washing your whole body?	1		2		3		4		5	
Getting dressed?	1		2		3		4		5	
Dealing with people you do not know?	1		2		3		4		5	
Maintaining a friendship	1		2		3		4		5	
Your day-to-day work?	1		2		3		4		5	
WHODAS Score total:										

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