AMHD
ADULT MENTAL HEALTH DIVISION

Utilization Management
PO Box 3378 Honolulu, Hawaii 96801-3378
Phone: 453-6904, 453-6981 Fax: 453-6989

Service Authorization Request	Representative Payee

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:	Social Security :	Phone:
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.

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 representative payee 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.

Mental Health Professional (MHP) Name: (Please Print)
A complete description of the definition and role of the MHP is located in attachment K.
Signature:

Authorization Information

Admit ☐ Date: _________ Cont. ☐ Date: _________ Discharge ☐ Date: _________

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Authorization Information Continued

Admission Criteria: (Must meet one of the following)	
	Is receiving SSI or SSDI
	Has a demonstrated inability to manage financial resources appropriately.
	Has the cognitive wherewithal and willingness to manage own finances within two (2) years of initial service authorization.

Continuation Criteria: (Must meet one of the following)	
	Intensity of service being delivered continues to meet admission criteria
	Consumer shows a willingness, **and has the cognitive wherewithal** to actively participate in financial management training/coaching. Consumer clearly demonstrates progress in treatment plan/goals.

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		Unable to participate in goal setting		Hospitalization	
Long term incarceration		Refuses Treatment		Clinically Ready For Discharge		Moved from State	
Other Discharge Criteria (please specify):							
Discharge to:							

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