



**Utilization Management**

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

<b>Service Authorization Request</b>	<b>SPECIALIZED RESIDENTIAL SERVICES PROGRAM</b>
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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:
Encumbered: Yes <input type="checkbox"/> No <input type="checkbox"/> Conditional Release (CR), Released on Conditions (ROC), Mental Health Court, and Jail Diversion		

**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 <b>not eligible</b> for the authorization of SRSP under AMHD unless encumbered.</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:

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:

**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: \_\_\_\_\_



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**Authorization Information Continued**

<b>Admission Criteria:</b> (Must meet one of the following)	
	Exacerbated psychiatric illness that would likely result in hospitalization/re-hospitalization, arrest or other seriously disruptive consequences if illness is not stabilized.
	Consumer is forensically encumbered (Conditional Release, Released on Conditions, Mental Health Court, and Jail Diversion).
	Individual requires a step down from a higher psychiatric level of care to stabilize gains made and develop skills necessary to transition to a less restrictive environment.

<b>Continuation Criteria:</b> (Must meet at least one of the following)	
	Intensity of service being delivered continues to meet admission criteria. <b>If this is selected the request must be accompanied by a current treatment plan.</b>
	Complications arising from initiation of, or change in, medication or other treatment modalities. <b>If this is selected the request must be accompanied by clinical documentation of the change in medication or other modalities.</b>
	Forensically Encumbered (Conditional Release, Released on Conditions, Mental Health Court, and Jail Diversion). <b>If this is selected the request must be accompanied by the court order.</b>
	Consumer is experiencing symptoms of such intensity that admission to a higher level of care would likely occur upon discharge. <b>If this is selected the request must be accompanied by clinical documentation of presenting symptoms requiring continued care.</b>

<b>Discharge Criteria:</b>							
Deceased		Unable to locate		Requires Higher LOC		Hospitalization	
Clinically Ready For Discharge		Refuses Treatment		Incarceration		Linked with CCS	
Moved from State/County		Other Payor		No longer encumbered		Long-term care	
Other Discharge Criteria (please specify):							
Discharge to:							

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



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<b>WHODAS</b>	<b>In the past 30 days how much difficulty did you have in:</b>										
		<b>None</b>		<b>Mild</b>		<b>Moderate</b>		<b>Severe</b>		<b>Extreme or cannot do</b>	
	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	
	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		
<b>WHODAS Score total:</b>											

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