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

Service Authorization Request

Homeless Outreach

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:

Provider Information

Agency:	Submitted by:
Phone:	Fax:
Signature of staff submitting request:	Date of Submission:

Authorization Information

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

Authorization Information Continued

Admission Criteria: (Must Meet **all** of the following)	
	Consumer is at least 18 years of age and is presumed to have a severe disabling mental illness or severe disabling mental illness co-morbid with substance abuse with no fixed place of residence.
	Consumer is currently **not** receiving CBCM, is **not** a CCS member or linked with a CMHC.
	Consumer is in need of treatment, housing or other services, and is likely to meet the eligibility criteria to receive AMHD funded services.
Continuation Criteria: (Must **one** of the following)	
	Has not completed an Eligibility Determination; though Outreach workers continue to engage.
	Consumer only tolerates contact without linkage to AMHD funded services.

Discharge Criteria:							
Deceased	☐	Unable to locate	☐	Ineligible for AMHD services	☐	Moved from State/County	☐
Linked with CBCM or CCS	☐	Refuses Treatment	☐	Incarceration	☐	Other (explain below)	☐
Other Discharge Criteria (please specify):							
Discharge to:							