AMHD
ADULT MENTAL HEALTH DIVISION

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

Service Authorization Request	Supportive Housing

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:
Is this Consumer Homeless: Yes ☐ No ☐	Is this Consumer a Veteran: Yes ☐ No ☐	

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:

All Support services require linkage with case management.

Provider Information

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

Authorization Information

Admit	Date:	Cont.	Date:	Discharge	Date:

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:	

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Authorization Information (continued)

Admission Criteria: (Must Meet all of the following)	
	There is a need for permanent housing and the consumer possesses both the capacity and motivation to abide by general tenancy requirements.
	Consumer is eligible to receive AMHD services.
	The consumer is linked with and actively working with a case manager.
	The consumer's annual income must fall at or below the current Federal Poverty Level Guidelines (FPL)

Continuation Criteria: (Must meet all of the following)	
	Consumer is receiving Bridge Subsidy, Section 8 or Shelter Plus.
	Intensity of service being delivered continues to meet admission criteria

Discharge Criteria:							
Deceased	☐	Unable to locate	☐	Requires Higher LOC	☐	Hospitalization	☐
Clinically Ready For Discharge	☐	Refuses Treatment	☐	Incarceration	☐	Moved from State/County	☐
Other Discharge Criteria (please specify):							
Discharge to:							

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