PROJECT BRAVO
BEHAVIORAL HEALTH REDESIGN FOR ACCESS, VALUE & OUTCOMES

CLEAR FORM

VIRGINIA'S MEDICAID PROGRAM DMAS

THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Community Stabilization (S9482)
INITIAL Service Authorization Request Form

Please be mindful of notes throughout this form providing reference to where documentation obtained during the Comprehensive Needs Assessment (CNA) are relevant and can be used for efficiency.

MEMBER INFORMATION		PROVIDER INFORMATION	
Member First Name:		Organization Name:	
Member Last Name:		Group NPI #:	
Medicaid #:		Provider Tax ID #:	
Member Date of Birth:		Provider Phone:	
Gender:		Provider E-Mail:	
Member Plan ID #:		Provider Address:	
Member Street Address:		City, State, ZIP:	
City, State, ZIP:		Provider Fax:	
Member Phone #:		**Clinical Contact** Name and Credentials*:	
Parent/Legal Guardian Name (s):		Phone #	
Parent/Legal Guardian Phone #:		* *The individual to whom the MCO can reach out to in order to gather additional necessary clinical information.*	

Request for Approval of Services			
Retro Review Request?	**Yes** ○ **No** ○	Data Platform Reference #:	
If the member is currently participating in this service, start date of service:			

Proposed/Requested Service Information:

From _____ (date), To _____ (date), for a total of _____ units of service.

Identify all known treatment periods of Community Stabilization and other behavioral health services that have been provided by any providers including the requesting provider in the past 30 calendar days:

Provider	**Dates of Service/Intervention**	**Outcomes**

Primary ICD-10 Diagnosis	
Secondary Diagnosis(es)	

Other medical/behavioral health concerns (including substance use issues, personality disorders, dementia, cognitive impairments) that could impact services? ◯Yes ◯No (If yes, explain below.)

SECTION I: ADMISSION CRITERIA

Individuals must meet ALL of the following criteria; note that some criteria have multiple sub-criteria for consideration.

1. Specify the DSM diagnosis or provisional diagnosis corresponding with the ICD-10 diagnosis(es).

Describe the individual's current symptoms (including frequency, intensity and duration) and areas of functional impairment. Corresponding CNA Elements: 1, 6, 7, 12

2. The individual is at risk of repeat admissions to crisis services, emergency departments, or psychiatric inpatient services or dangerous decompensation in functioning and additional support is required to prevent inpatient admission. *Is the individual able to sustain safety during the interim period between services, if not, why? Describe any repeated occurrences of behaviors that are endangering to self or others, are difficult to control, cause distress, or other evidence that the individual is at risk of crisis-cycling or dangerous decompensation and an acute inpatient admission.*

Member Full Name: Medicaid #:

Prior to admission the individual must meet **either #3 or #4 below**:

3. The individual is currently residing in a Therapeutic Group Home (TGH) or ASAM 3.1. *Please provide TGH provider name, address and clinical contact information.*

Provider Name: _____

Provider Address: _____

Clinical Contact Name: _____

Clinical Contact Phone: _____ Clinical Contact Email: _____

Notes: _____

If yes, skip to Section II: Other Required Information

○ Yes ○ No

4. The individual is transitioning from one of the following services and the necessary service is not immediately available:

_____

Please provide provider/agency name, address and contact information for the identified professional coordinating the discharge plan.

Provider Name: _____

Provider Address: _____

Contact Name: _____

Contact Phone: _____ Contact Email: _____

Notes: _____

○ Yes ○ No

If the individual meets criteria #4, then the following additional criteria (#5 and #6) must be met:

5. Without immediate access to the identified community-based service, there is evidence that the individual would be at risk for a higher level of care during the transition to the next service. *Provide evidence that the individual is not able to sustain safety during the service transition.*

○ Yes ○ No

6. Clinically appropriate behavioral health service referral(s) has been identified and the service that the individual needs is not currently available for immediate access. *What is the intended service (name and procedure code) and what are the barriers to immediate availability?*

Name and Procedure Code of identified Behavioral Health service: _____

○ Yes ○ No

6a. A clinically appropriate and specific behavioral health service provider referral(s) has been identified and a plan for the timeline of transition from Community Stabilization to that provider has been established and documented. *Provide details about the transition plan: specific dates and times for the assessment or start of service, and any details about transition sessions.*

Provider Name/Agency: _____

Provider Address: _____

Contact Name: _____

Contact Phone: _____ Contact Email: _____

Notes: _____

○ Yes ○ No

If the timeline for this transition (#iii,b) exceeds 2 weeks, the Community Stabilization provider has documented communications with additional, specific service providers to support additional service options or potentially faster access to the recommended service type. *Please provide additional referral information, service type/ procedure code, provider and contact information (if applicable).*

Member Full Name: Medicaid #:

Section II: OTHER REQUIRED INFORMATION

Along with this document, please include the following with your submission (if applicable):

Documented referral from discharging provider/agency.

The referral must include the following:
1. Name of the individual;
2. Name and credentials of the referring provider;
3. Reason for referral;
4. Anticipated length of service needed;
5. Name of the Community Stabilization provider submitting the authorization.

By my signature (below), I am attesting that 1) an LMHP, LMHP-R, LMHP-S or LMHP-RP has reviewed the individual's psychiatric history and completed the appropriate assessment or addendum; and 2) that this assessment indicates that the individual meets the medical necessity criteria for the identified service. The assessment or applicable addendum for this service was completed on the following date: _____

Signature (actual or electronic) of LMHP (Or R/S/RP): _____

Printed Name of LMHP (Or R/S/RP): _____

Credentials: _____ NPI #: _____

Date: _____

Notes