

## ACT OTR FORM

Date: _____	Member Name: _____
<input type="checkbox"/> Initial Request	# Units requested: _____
<input type="checkbox"/> Continued Stay/Requesting additional units Last authorization #: _____	CPT: <u>H0039</u> Modifiers: _____
Date member initially start receiving services: _____  Units will be authorized at 1 unit per month.	Authorization Start Date: _____  Authorization End Date: _____
Member DOB: _____	Medicaid/Health Plan #: _____
Legal Guardian if not self: _____	Member Phone #: _____
Member Address: _____	City, State: _____ Zip: _____
Requesting Provider: _____ NPI#: _____ TIN#: _____ LMHP/MD Name: _____ Contact Name: _____ Contact Phone: _____ Contact Fax: _____ Contact Email: _____	Servicing Provider: <input type="checkbox"/> same as requesting NPI#: _____ TIN#: _____ LMHP/MD Name: _____ Contact Name: _____ Contact Phone: _____ Contact Fax: _____ Contact Email: _____
DSM Diagnosis code: _____	
ICD-10 Code: _____	
Level of Functional Impairment: <input type="checkbox"/> No Impairment <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
Risk of Harm to Self or Others: <input type="checkbox"/> No Risk <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
Progress Towards Goals: <input type="checkbox"/> N/A (initial request) <input type="checkbox"/> Making Progress Towards Goals <input type="checkbox"/> Lack of Adherence and/or Progress	

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### PLEASE SUBMIT THIS FORM WITH THE FOLLOWING ITEMS:

**For initial authorization:**

<input type="checkbox"/>	An initial assessment that includes psychiatric history, mental status exam, diagnosis, and information needed to determine medical necessity and if the member meets eligibility criteria to receive ACT services.
<input type="checkbox"/>	LOCUS scoresheet signed by an LMHP, on a form that includes the rating in each dimension, the criteria to support the rating, independent criteria, the composite score, the level of care, a section to document notes, a signature line with credentials, and a rating date.
<input type="checkbox"/>	Initial Treatment plan (including goals with focus of treatment and transition/discharge plan) with signatures of member, team leader, and prescriber.
<input type="checkbox"/>	Member Choice/Freedom of Choice Form

**For continuing stay authorization:**

<input type="checkbox"/>	<p>“Comprehensive person-centered needs assessment” updated every 6 months</p> <ul style="list-style-type: none"> <li>• The sections of the person-centered needs assessment shall be completed by ACT team members with subject matter expertise as indicated by their role within the program.</li> <li>• The entire assessment shall be reviewed and signed off on by the licensed mental health professional (LMHP)</li> </ul>
<input type="checkbox"/>	LOCUS score sheet signed by an LMHP, on a form that includes the rating in each dimension, the criteria to support the rating, independent criteria, the composite score, the level of care, a section to document notes, a signature line with credentials, and a rating date. Needs to be updated every 6 months.
<input type="checkbox"/>	Treatment plan (including goals with focus of treatment and transition/discharge plan) updated every 3 months with signatures of member, team leader, and prescriber.
<input type="checkbox"/>	ACT Transition Assessment Scale updated every 6 months
<input type="checkbox"/>	Career Profile / Vocational assessment updated every 6 months
<input type="checkbox"/>	<p>Progress Summary completed within the past 30 days of the continuing stay authorization request. A Progress Summary shall include the following:</p> <ul style="list-style-type: none"> <li>• Document the time period summarized;</li> <li>• Indicate who was contacted, where contact occurred and what activity occurred;</li> <li>• Record activities and actions taken, by whom, and progress made;</li> <li>• Indicate how the member is progressing toward the personal outcomes in the treatment plan, as applicable;</li> <li>• Document delivery of each service identified on the treatment plan, as applicable;</li> <li>• Document any deviation from the treatment plan;</li> <li>• Record any changes in the member's medical condition, behavior or home situation that may indicate a need for a reassessment and treatment plan change, as applicable;</li> <li>• Be legible (including signature) and include the functional title of the person making the entry and date</li> </ul>

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By my signature below, I hereby attest that all of the information above is true and accurate to the best of my knowledge.

Printed LMHP/Provider Name and Credentials:

Signature of Provider/Clinician:

Submitted by:

Date: