# Addictive and Mental Disorders Division Mental Health Continued Stay Review Form

*All forms must be typed. Handwritten or incomplete forms will be returned.*

*Refer to the Addictive and Mental Disorders Division Medicaid Services Provider Manual for Substance Use Disorder and Adult Mental Health for information pertaining to Utilization Management process and requirements.*

**Requested Service Type:**

|  |  |  |
| --- | --- | --- |
| PACT (Complete Page 1,2 & Form A) up to 180 days | ICBR (Complete Page 1,2 & Form B) up to 180 days | AGH (Complete Page 1,2 & Form C) up to 90 days |
| Crisis Stabilization Program (Complete Page 1, 2 & Form D) | |  |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Provider Information** | | | | | | | | | | |
| Provider Name: | Enter Text |  | Address: | | Enter Text | | |  | City: | Enter Text |
| Phone Number: | Enter Text |  | Fax: | Enter Text | |  | Provider ID: | | Enter Text | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Demographics** | | | | | | | | | | | | | |
| Member Name: | Enter Text |  | Birthdate: | | Enter Text |  | Medicaid # | | | | | Enter Text | |
| Address: | Enter Text |  | City: | Enter Text | | | |  | Zip: | | Enter Text | | |
| Phone: | Enter Text |  | Cell: | Enter Text | | | |  | Social Security #: | | | | Enter Text |
| Does member have a legal guardian/power of attorney?  Yes  No | | | | | | | | | | | | | |
| Guardian Name: | Enter Text |  |  | Relationship to member: | | | | Enter Text | | | | | |
| Address: | Enter Text |  | City: | Enter Text | | | |  | Zip: | Enter Text | | | |
| Phone: | Enter Text |  | Cell | Enter Text | | | |  |  | | | |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Primary SDMI Diagnosis** | | | | | | |
| Primary SDMI Diagnosis: | | Enter text. | ICD-10 Code: | |  | Enter text. |
| Description: | Enter text. | | | | | |
| Additional diagnosis relevant to treatment (Enter N/A if not applicable): | | | | Enter text. | | |
| The member meets the criteria for having an SDMI, including specific functional impairment criteria: | | | | | | |
| Yes  No | | | | | | |
| Has the member been involuntarily hospitalized for at least 30 consecutive days because of a mental disorder at the Montana State Hospital in the past 12 months?  Yes  No | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Section A** | | | |
| Initial assessment completion date: | Enter Text | Completed By: | Enter Text |
| Is the initial assessment attached?  Yes  No Is the latest clinical assessment attached?  Yes  No | | | |
| Date of last clinical assessment: Enter Text | | Requested Start Date: Enter Text | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Section B: Hospitalizations in the past three years:** (attach additional sheets if needed) | | | |
| **Facility Name** | **Admission Date** | **Discharge Date** | **Reason for Admission** |
| Enter Text | Enter Text | Enter Text | Enter Text |
| Enter Text | Enter Text | Enter Text | Enter Text |
| Enter Text | Enter Text | Enter Text | Enter Text |
| Enter Text | Enter Text | Enter Text | Enter Text |
| Enter Text | Enter Text | Enter Text | Enter Text |
| Enter Text | Enter Text | Enter Text | Enter Text |
| Enter Text | Enter Text | Enter Text | Enter Text |
| Enter Text | Enter Text | Enter Text | Enter Text |

|  |  |  |
| --- | --- | --- |
| **Section C: Current Medication- Psychiatric and Medical.** (attach additional sheets if needed) | | |
| **Medication** | **Dose** | **Schedule** |
| Enter Text | Enter Text | Enter Text |
| Enter Text | Enter Text | Enter Text |
| Enter Text | Enter Text | Enter Text |
| Enter Text | Enter Text | Enter Text |
| Enter Text | Enter Text | Enter Text |
| Enter Text | Enter Text | Enter Text |
| Enter Text | Enter Text | Enter Text |
| Enter Text | Enter Text | Enter Text |
| Enter Text | Enter Text | Enter Text |
| Enter Text | Enter Text | Enter Text |
| Enter Text | Enter Text | Enter Text |
| Enter Text | Enter Text | Enter Text |
| Enter Text | Enter Text | Enter Text |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Licensed Mental Health Professional Name:** | | Enter Text |  | **Credentials:** | Enter Text |
| **Signature:** | Enter Text | |  | **Date:** | Enter Text |

**Addictive and Mental Disorders Division**

**Form A - Program of Assertive Community Treatment (PACT)**

**IMPORTANT - In determining eligibility, all criteria that is checked must include supporting individualized information. Requests missing individualized information will be considered incomplete and will be denied.**

**Section D: Continued stay requests will be considered only when the member continues to meet the SDMI eligibility criteria and all of the following:** (attach additional sheets if needed)

The prognosis for treatment of the member at a less restrictive level of care is poor because the member demonstrates the following due to the SDMI: significantly impaired interpersonal or social functioning; significantly impaired occupational functioning; impaired judgment; poor impulse control; and/or lack of family or other community or social supports. (Enter individualized information below)

Enter Text

As a result of the SDMI, the member exhibits an inability to perform daily living activities in a developmentally appropriate manner without the structure of the PACT service. (Enter individualized information below)

Enter Text

The SDMI symptoms of the member are of a severe or persistent nature requiring more intensive treatment and clinical supervision than can be provided by other outpatient or in-home mental Health Services. (Enter individualized information below)

Enter Text

**Section E The member continues to require at least three of the following services:**

Medication Management  Vocational Services  Co-Occurring Services

Community Psychiatric Support Treatment  Psychotherapy  Skills training

**Section F The member demonstrates progress toward treatment goals and has a reasonable likelihood of continued program as evidenced by:** (attach additional sheets if needed)

(Enter individualized information below)

Enter Text

**Section G Discharge Plan:** **(attach additional sheets if needed)** **Anticipated Discharge Date:**

(Enter individualized information below)

Enter Text

# Fax completed Page 1 & 2 and Form A to:

# Telligen Medicaid Administration

**Fax: 1-833-574-0650 Phone: 866-545-9428**

**Addictive and Mental Disorders Division**

**Form B – Intensive Community-Based Rehabilitation (ICBR)**

**MPORTANT - In determining eligibility, all criteria that is checked must include supporting individualized information. Requests missing individualized information will be considered incomplete and will be denied.**

**Section D The member continues to exhibit behaviors related to the SDMI diagnosis that result in significant risk for placement in the MSH, MMHNCC, or acute hospital inpatient care if services are not provided to be successfully treated in a less restrictive setting and the following:**

Active treatment is occurring, which is focused on stabilizing or alleviating the psychiatric symptoms and precipitating psychosocial stressors that are interfering with the ability of the member to receive services in and less intensive outpatient setting. (Enter individualized information below)

Enter Text

Demonstrated and documented progress is being made towards the treatment goals and there is a reasonable likelihood of continued progress. (Enter individualized information below)

Enter Text

ICBR is the least restrictive service to meet the clinical needs of the member. (Enter individualized information below)

Enter Text

**Section E Discharge Plan:** **(attach additional sheets if needed)** **Anticipated Discharge Date:**

(Enter individualized information below)

Enter Text

# Fax completed Page 1 & 2 and Form B to:

# Telligen Medicaid Administration

**Fax: 1-833-574-0650 Phone: 866-545-9428**

**Addictive and Mental Disorders Division**

**Form C – Adult Group Home**

**MPORTANT - In determining eligibility, all criteria that is checked must include supporting individualized information. Requests missing individualized information will be considered incomplete and will be denied.**

**Section D The member continues to exhibit behaviors related to the SDMI diagnosis that result in significant risk for placement in the MSH, MMHNCC, or acute hospital inpatient care if services are not provided to be successfully treated in a less restrictive setting and the following:**

Active treatment is occurring, which is focused on stabilizing or alleviating the psychiatric symptoms and precipitating psychosocial stressors that are interfering with the ability of the member to receive services in and less intensive outpatient setting. (Enter individualized information below)

Enter Text

Demonstrated and documented progress is being made towards the treatment goals and there is a reasonable likelihood of continued progress. (Enter individualized information below)

Enter Text

AGH is the least restrictive service to meet the clinical needs of the member. (Enter individualized information below)

Enter Text

**Section E Discharge Plan:** **(attach additional sheets if needed)**  **Anticipated Discharge Date:**

(Enter individualized information below)

Enter Text

# Fax completed Page 1 & 2 and Form C to:

# Telligen Medicaid Administration

**Fax: 1-833-574-0650 Phone: 866-545-9428**

**Addictive and Mental Disorders Division**

**Form D – Crisis Stabilization Program**

**MPORTANT - In determining eligibility, all criteria that is checked must include supporting individualized information. Requests missing individualized information will be considered incomplete and will be denied.**

**Section D Any mental health diagnosis from the current version of the DSM as the primary diagnosis and the following: (attach additional sheets if needed)**

Active treatment is occurring, which is focused on stabilizing or reversing symptoms that meet the admission criteria: (Enter individualized information below) and

Enter Text

The lower level of care is inadequate to meet the member’s treatment or safety needs. (Enter individualized information below)

Enter Text

**Section E In addition to section D above, any one of the following: (attach additional sheets if needed)**

There is reasonable likelihood of a clinically significant benefit resulting from medical intervention requiring the inpatient setting; (Enter individualized information below)

Enter Text

There is a high likelihood of either risk to the member’s safety, clinical well-being, or of further significant acute deterioration in the member’s condition without continued care and lower levels of care inadequate to meet these needs; (Enter individualized information below) or

Enter Text

The appearance of new impairments meeting admission guidelines. (Enter individualized information below)

Enter Text

**Section F Discharge Plan:** **(attach additional sheets if needed)**  **Anticipated Discharge Date:**

(Enter individualized information below)

Enter Text

# Fax completed Page 1 & 2 and Form D to:

# Telligen Medicaid Administration

**Fax: 1-833-574-0650 Phone: 866-545-9428**