Residential Prior Authorization Form for Initial Request

Requesting RTC/RTU Provider:	OP Provider Name:	
City/Location:		Contact Number:
Member ID:	Member DOB:	Member First and Last Name:

Behavioral Health Diagnosis (include most recent and any previous diagnosis):

Has the member received any Home- and Community-Based Services (HCBS) in the last 90 days?

Services:

Frequency:

Individual therapy sessions in the last 90 days?

Frequency:

Last Session:

Family therapy sessions in the last 90 days?

Frequency:

Last Session:

Is the member/family noncompliant with any treatment services? If yes, explain:

Does the member receive medication management?

Frequency:

Last Session:

Has the member been compliant with medications? ☐ Yes ☐ No

Has the member received crisis intervention in the last 90 days? If so, state when and describe the outcome:

List problems identified in the members, treatment plan and what progress or lack thereof has occurred:

Does the member have a strong support system? Please explain:

Is the member in DCFS custody? If so, please list caseworker and contact number if available:

Does the member have legal charges? If so, state them:

List current symptoms/behaviors preventing the member from being managed safely through HCBS and counseling services:

Has the member had any recent acute hospitalizations or emergency department visits for a behavioral health reason? If so, please list dates/reasons for any over the last 90 days:

If the member has not had OP in the last 90 days and needs residential treatment, please explain their barriers for OP treatment and why residential is recommended:

If the member has previously been in residential, what will the requesting residential provider provide that is different from the previous admission?

Are you recommending a residential level of care for this member? ☐ **Yes** ☐ **No**

Name of Licensed Mental Health Professional:	Signature: **X**	Date: