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 diagnoses):

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 member's 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:

Please describe the specific symptoms and/or behaviors the member has exhibited consistently over the past six months. Include any resulting harm or injury to the member, others, or property, if applicable.

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: