HCBS Outpatient Treatment Request Form

Please utilize specific forms on our website for Family-Centered Therapy, Therapeutic Communities, and Community Reintegration requests.

Submit To:
Utilization Management Department
Fax: **833-632-6934**

Please print clearly. Incomplete or illegible forms will delay processing.

Member Information		
Name	DOB	Member ID #

Provider Information		
Provider Name (print)	Provider/Agency Tax ID #	
Provider/Agency NPI Sub Provider #	Phone	Fax

Current ICD Diagnoses	
Primary	
Secondary	Tertiary
Additional	Date first seen by provider/agency
Additional	Date first seen by provider/agency

Functional Outcomes			
1	In the last 30 days, the member had trouble getting along with other people including family and people out the home?	☐ Yes	☐ No
2	In the last three months, has the member had trouble following the rules at home or school?	☐ Yes	☐ No
3	In the last three months, has the member been placed in DCFS state custody?	☐ Yes	☐ No
4	Is the member currently in DCFS custody?	☐ Yes	☐ No

Indicate Previously Received Services

☐ Individual Therapy ☐ Family Therapy ☐ Group Therapy ☐ Family-Centered Treatment
☐ Inpatient Hospitalization ☐ Residential Treatment

Has the member been diagnosed with Autistic Spectrum Disorder? ☐ Yes ☐ No

If prescribed medication, is member compliant? ☐ Yes ☐ No

Please list all current medications:

Level of Improvement to Date

☐ Major ☐ Moderate ☐ Minor ☐ No progress to date

Barriers to discharge:

Symptoms in The Last Three Months (check degree to which it impacts daily functioning)

	N/A	Mild	Moderate	Severe		N/A	Mild	Moderate	Severe
Anxiety/Panic Attacks	☐	☐	☐	☐	Hyperactivity/Inattention	☐	☐	☐	☐
Decreased Energy	☐	☐	☐	☐	Irritability/Mood Instability	☐	☐	☐	☐
Depressed Mood	☐	☐	☐	☐	Impulsivity	☐	☐	☐	☐
Delusions	☐	☐	☐	☐	Oppositional/Defiant	☐	☐	☐	☐
Hallucinations	☐	☐	☐	☐	Aggression	☐	☐	☐	☐
Angry Outbursts	☐	☐	☐	☐	Other (include severity):				

Please Indicate Historical Symptomology Data

Unctional Impairment Related Symptoms in The Last Three Months (Check Degree to Which It Impacts Daily Functioning.)					
	N/A	Mild	Moderate	Severe	Last Date of substance use:
ADLs	☐	☐	☐	☐	
Impact to Relationships	☐	☐	☐	☐	Drug(s) of Choice:
Substance Abuse	☐	☐	☐	☐	
Physical Health	☐	☐	☐	☐	
Impact to Work/School	☐	☐	☐	☐	

Risk Assessment					
Suicidal	☐ None	☐ Ideation	☐ Planned	☐ Imminent Intent	☐ History of self-harming behavior
Homicidal	☐ None	☐ Ideation	☐ Planned	☐ Imminent Intent	☐ History of self-harming behavior
Safety Plan in place? (If plan or intent indicated):	☐ Yes	☐ No			

Current Measureable Treatment Goals (please Attach Complete Treatment Plan With Request)

Requested Authorization (please select all requests HCBS services)			
HCBS Services	Requested Start Dates & End Dates For Each Service		Units Requested per Service:
☐ **H2015**: Child & Youth Services	Start:	End:	
☐ **H2019**: Behavioral Assistance	Start:	End:	
☐ **H0038**: Peer Support	Start:	End:	
☐ **H0034**: Pharmacological Counseling	Start:	End:	
H2017 (select service below):			
☐ Adult Life Skills	Start:	End:	
☐ Adult Rehab Day	Start:	End:	
☐ Supportive Life Skills	Start:	End:	
Other Code Not Listed:			

Provider name: _____ Date: _____

Provider signature: _____

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