# Therapeutic Communities H0019 Template — Level 1

## Member Information

| Member Name: | Start Date of Dates Requested: |
|---|---|
| Total Treatment Hours for Last 30 Days (Minimum 140 hours): | |

## Clinical Justification

Please explain the member's current regression or exacerbation of symptoms that require 24/7 supervision, support, and treatment to ensure community safety:

## Legal Status

Current Legal Status:

Is the member on a 911, 310, or 180 commitment status? ☐ Yes ☐ No

If yes, specify:

## Crisis and Hospitalization History

Please list inpatient hospitalizations and/or crisis emergency services needed over the last year (include type(s) of service and date span(s)):

## Violence/Assault History

Does the member have a history of violence or assault? ☐ Yes ☐ No

If yes, provide details:

## Transition Planning

List transition plans, including considerations for Level 2:

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**Required Attachments**

Please include the following with all submissions:

1. ☐ Arkansas Total Care fax cover form (completed)
2. ☐ Medication list
3. ☐ Legal documents/court orders
4. ☐ This template (completed)

**Initial Authorization Requirements**

☐ Documentation noting frequency of services to demonstrate Level 1 requirements will be met

☐ Clinicals and information supporting this level of service (may be from referring provider)

**Continued Stay Requirements**

☐ Most recent treatment plan

☐ Psychiatric evaluation

☐ Prescriber/MD notes

☐ Medication list

☐ Counseling notes by a licensed mental health professional

☐ Daily notes/logs showing treatment hour requirements met for the last 30 days

**Level 1 Progress Notes Must Include (Last 30 Days):**

☐ Two (2) MD/APRN/Prescriber notes for the member's behavioral health need(s)

☐ Twenty (20) counseling notes by licensed mental health professional **(with a minimum of four of these conducted on an individual basis and not in a group setting)**

— ☐ Include duration of each encounter