

FORWARDHEALTH
PRIOR AUTHORIZATION / INTENSIVE IN-HOME TREATMENT ATTACHMENT (PA/ITA)

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Intensive In-Home Treatment Attachment (PA/ITA) Completion Instructions, F-11036A. Providers may submit prior authorization (PA) requests to ForwardHealth by fax at (608) 221-8616 or by mail to: ForwardHealth, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)	2. Date of Birth — Member	3. Member Identification Number
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SECTION II — PROVIDER INFORMATION

4. Name — Rendering Provider	5. Rendering Provider's National Provider Identifier
6. Telephone Number — Rendering Provider	7. Credentials — Rendering Provider

SECTION III — SERVICE REQUEST

8. **CHECK ONE** Initial Authorization Second Authorization Third Authorization Fourth Authorization

9. Enter the requested start and end dates for this authorization request. If backdating is needed for the initial PA request, it must be requested in writing, and the clinical rationale for starting services before authorization is obtained must be documented.

10. Enter the name and credentials of the second team member. Include his or her degree and the number of hours of supervised clinical work he or she has done with severe emotional disturbance (SED) children in the space provided (attach résumé, if available).

11. Enter the pattern and frequency of treatment planned over this PA grant period.
Certified Psychotherapist/Substance Abuse Counselor — ALONE

Individual Sessions: _____ hours per session; _____ sessions per week.

Family Sessions: _____ hours per session; _____ sessions per week.

Certified Psychotherapist / Substance Abuse Counselor and Second Team Member — TOGETHER

Individual Sessions: _____ hours per session; _____ sessions per week.

Family Sessions: _____ hours per session; _____ sessions per week.

Second Team Member — ALONE

Individual Sessions: _____ hours per session; _____ sessions per week.

Family Sessions: _____ hours per session; _____ sessions per week.

12. Enter the travel time requested for this PA grant period. (The maximum allowable quantity of travel time is the time actually required for travel from either the office and home, or the previous appointment and home, whichever is less.)

Certified Psychotherapist / Substance Abuse Counselor

Second Team Member

Total Number of Visits: _____

Total Number of Visits: _____

Travel Time per Visit x _____ Hours

Travel Time per Visit x _____ Hours

Total Travel Time = _____ Hours

Total Travel Time = _____ Hours

Continued



SECTION IV — SEVERELY EMOTIONALLY DISTURBED CRITERIA

13. Complete the checklist to determine whether or not the individual meets the criteria for SED. Criteria for meeting the functional symptoms and impairments are found in the instructions. The disability must be evidenced by a, b, c, and d listed below.
- a. A primary psychiatric diagnosis of mental illness or SED. Document diagnosis using the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* or *Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood (DC:0-3)*.
 Primary Diagnosis: _____.
 - b. The individual must meet all three of the following.
 - Be under the age of 21.
 - Have emotional and behavioral problems that are severe in nature.
 - This disability is expected to persist for a year or longer.
 - c. The individual must have one symptom or two functional impairments.
 - 1. Symptoms (must have one).
 - Psychotic symptoms.
 - Suicidality.
 - Violence.
 - 2. Functional impairments (must have two).
 - Functioning in self care.
 - Functioning in the community.
 - Functioning in social relationships.
 - Functioning in the family.
 - Functioning at school / work.
 - d. The individual is receiving services from one or more of the following service systems in addition to the mental health service system. (The multi-agency treatment plan must be developed by representatives from all systems identified on the SED eligibility checklist, address the role of each system in the overall treatment and the major goals for each agency involved.)
 - Social Services.
 - Child Protective Services.
 - Juvenile Justice.
 - Special Education.
 - e. Enrollment criteria may be waived under the following circumstances.
 - The member substantially meets the criteria for SED, except the severity of the emotional and behavioral problems have not yet substantially interfered with the individual's functioning, but would likely do so without in-home mental health and substance abuse treatment services. Attach an explanation.
 - The member substantially meets the criteria for SED, except the individual has not yet received services from more than one system and in the judgment of the medical consultant, would be likely to do so if the intensity of treatment requested was not provided.

SECTION V — ATTACH SUPPORTING DOCUMENTATION

14. Attach and label all of the following.
- a. The Prior Authorization Request Form (PA/RF), F-11018.
 - b. The assessment and recovery/treatment plan.
 - c. A copy of a physician's prescription/order for in-home treatment services dated not more than one year prior to the requested first date of service (DOS).
 - d. Documentation that the member had a comprehensive HealthCheck screening performed by a valid HealthCheck screener dated not more than one year prior to the first DOS.
 - e. The Child and Adolescent Needs and Strengths assessment summary, Child and Adolescent Functional Assessment Scale, or the Achenbach Child Behavior checklist.
 - f. A substance abuse assessment may be included. A substance abuse assessment must be included if substance abuse-related programming is part of the member's treatment program.

SECTION VI — SIGNATURE

I attest to the accuracy of the information on this PA request. I understand that I am responsible for the supervision of the other team member(s) identified on this attachment. I, or someone with comparable qualifications, will be available to the other team member(s) at all times when he or she is in the home alone working with the child/family.

15. SIGNATURE — Certified Psychotherapist / Substance Abuse Counselor	16. Credentials	17. Date Signed
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