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| UTILIZATION MANAGEMENT (UM) REQUEST AND AUTHORIZATION**CYF - Outpatient Treatment** |
| Client Name:       | Client #:       | Program:       |
|  **ADMISSION DATE:**       **CURRENT SERVICES & FREQUENCY:** [ ] MHS [ ] MHS-R [ ] CM [ ] Meds    sessions per month**Does youth/family request additional services?** YES[ ]  NO[ ]  Explain:       | **DIAGNOSIS:** **ICD-10 CODE(S):**        **DESCRIPTION:**  |
| **Psychiatric Hospitalizations:** YES [ ]  NO**[ ]** (*Provide relevant history)*:       **Other Services Client Receiving:**       **See CFARS dated:**       **at** [ ] **Admission**  **or** [ ] **UM Cycle** **CURRENT CFARS Reviewed:** [ ] YES [ ] NO |
| **RATIONALE FOR ADDITIONAL SERVICES:**      [ ]   **COR approved UM Exception. For**       **session cycle OR**       **months cycle** *(written exception on file).* [ ]   **New Client Plan was completed prior to UM request and reviewed by UM Committee** *(client/family input/signatures may be pending UM Approval)* |
| **ELIGIBILITY CRITERIA:** UM POST INITIAL 13 SESSIONS[ ]  **Client continues to meet Medical Necessity and demonstrates benefit from services*** Consistent participation: [ ] YES [ ] NO
* CFARS – Impairment Rating guideline of 5: [ ] YES [ ] NO
* Client meets criteria for Pathways to Well-Being Enhanced Services: [ ] YES [ ] NO

[ ]  **Client meets the criteria for SED based upon the following:**As a result of a mental disorder the child has **substantial** and **persistent** impairment in at least two of the following areas: [ ]  Self-care and self- regulation [ ]  Family relationships [ ]  Ability to function in the community [ ]  School functioning **AND One of the following occurs**: [ ]  Child at risk for removal from home due to a mental disorder [ ]  Child has been removed from home due to a mental disorder [ ]  Mental disorder/impairment is severe and has been present for six months, or is highly likely to continue for more than one year without treatment. **OR** **The child displays:**  [ ] acute psychotic features, [ ] imminent risk for suicide[ ] imminent risk of violence to others due to a mental disorder **ELIGIBILITY CRITERIA –** UM POST 26 SESSIONS(*Requires COR approval)*[ ]  **Client has met the above criteria as indicated AND Meets a minimum of one continuing current Risk Factor related to child’s primary diagnosis:** [ ] Child has been a danger to self or other in the last two weeks [ ] Child experienced severe physical or sexual abuse or has been exposed to extreme violent behaviors in the home in the last two weeks [ ] Child’s behaviors are so substantial and persistent that current living situation is in jeopardy [ ] Child exhibited bizarre behaviors in the last two weeks [ ] Child has experienced trauma within the last two weeks |
| **Proposed Treatment Modalities: Planned Frequency:**[ ]  Family Therapy       per month[ ]  Group Therapy       per month [ ]  Individual Therapy       per month[ ]  Collateral Services       per month[ ]  Case Management/Brokerage       per month[ ]  Individual Rehab       per month[ ]  Group Rehab       per month[ ]  Medication Services       per month**Pathways to Well-Being (Katie A. Subclass Only)**[ ]  Intensive Care Coordination       per month[ ]  Intensive Home Based Services       per month  | **Expected Outcome and Prognosis:**[ ]  Return to full functioning[ ]  Expect improvement but less than full functioning[ ]  Relieve acute symptoms, return to baseline functioning[ ]  Maintain current status/prevent deterioration |
| **REQUESTED NUMBER OF SESSIONS:**       | **REQUESTED NUMBER OF MONTHS:**       (for programs under written COR approval) |
| **PROGRAM REVIEW: ADDITIONAL UM CYCLE**Requestor’s Name, Credential & Signature: Date:       **Request:** [ ] Approved [ ] Reduced [ ] Denied Sessions/Time Approved:      Approver’s Name, Credential & Signature: Date:      Comments:       |
| **COR REVIEW: UM POST 26 SESSIONS****Request:**  [ ] Approved [ ] Reduced [ ] Denied [ ] Retroactive Authorization Sessions/Time Approved:      COR Name and Credentials:       Date Approved:       Comments:      (attach written COR approval; NOA-B may be required for Medi-Cal Clients) |