

The Illinois Mental Health Collaborative for Access and Choice

**Request for Authorization of Adult Community Support Team Services
(CST) Initial Request or Reauthorization Request**

Agency: _____ Agency Location: _____ Agency FEIN: _____	Name of Referred: _____ Date of Birth: _____ RIN # _____
Male: <input type="checkbox"/> Female: <input type="checkbox"/>	

I. Service Definition Criteria (Please check all that apply)

<input type="checkbox"/> Multiple and frequent psychiatric inpatient admissions;
<input type="checkbox"/> Excessive use of crisis or emergency services with failed linkages;
<input type="checkbox"/> Chronic homelessness;
<input type="checkbox"/> Repeat arrests and incarcerations;
<input type="checkbox"/> History of inadequate follow-through with elements of an ITP related to risk factors, including lack of follow through taking medications, following a crisis plan, or achieving stable housing.
<input type="checkbox"/> High use of detoxification services (e.g., two (2) or more episodes per year.)
<input type="checkbox"/> Clinical evidence of suicidal ideation or behavior in last three (3) months.
<input type="checkbox"/> Ongoing inappropriate public behavior within the last three months including (but not limited to) such examples as public intoxication, indecency, disturbing the peace.
<input type="checkbox"/> Self harm or threats of harm to others within the last three (3) months.
<input type="checkbox"/> Medication resistance due to : intolerable side effects or illness-mediated interference with consistent self-management of medications

II. DIAGNOSIS

DSM Diagnosis <i>All 5 Axes must be completed</i>	Diagnosis (Code)	Rank (Please rank diagnoses in Axes 1-3 in order of primacy)
Axis I		
Axis II		
Axis III		
Axis IV		
Axis V - Global Assessment of Functioning (GAF)	Highest Last Year:	Current:

III. FUNCTIONAL IMPAIRMENT (Fill out all domains from the LOCUS tool)

Domain Scores: Risk of Harm: _____ Recovery Environment - Environmental Stressors: _____ Recovery Environment – Environmental Support: _____ Functional Status: _____ Co-morbidity: _____ Recovery and Treatment History: _____ Acceptance and Engagement: _____
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Date of Birth: _____ RIN # _____

LOCUS RECOMMENDED LEVEL OF CARE: Composite Score: _____

Level I Level II Level III Level IV Level V Level VI

ASSESSOR RECOMMENDED LEVEL OF CARE (according with services crosswalk)

Level I Level II Level III Level IV Level V Level VI

Reason for deviation (if applicable)

Explain:

Other Rule 132 Services on treatment plan:

Service: _____ Provided by: _____

Service: _____ Provided by: _____

Clinical staff to contact with any questions (print) _____

Phone: (_____) _____ Fax Number: (_____) _____

Encrypted email address: _____

Please attach the following to this request form:

The current treatment plan

The Consumer's Crisis Plan

TRANSITION PLAN (NARRATIVE)

This section is to be used when CST authorization is requested as part of a transition plan. (Please write legibly.)

Please describe the clinical need for the transition to less intensive services or more intensive services (such as ACT)

Describe contacts already made to facilitate the transition

Describe issues that need to be addressed before transition can occur etc.

Please note that incomplete forms will be returned

Your signature below verifies the medical necessity for this Request for Authorization. Specifically, it verifies that the attached Treatment Plan is recommended by an LPHA and is based upon a completed Mental Health Assessment which is in the consumer's clinical record and available upon request. Yes