FUNCTIONAL OUTCOMES
(To be completed by provider during a face-to-face interview with member or guardian. Questions are in reference to the patient.)

1. In the last 30 days, have you/your child had problems with sleeping or feeling sad?    Yes (5)  No (0)
2. In the last 30 days, have you/your child had problems with fears and anxiety?    Yes (5)  No (0)
3. Do you/your child currently take mental health medicines as prescribed by your doctor?   Yes (0)  No (5)
4. In the last 30 days, has alcohol or drug use caused problems for you or your child?    Yes (5)  No (0)
5. In the last 30 days, have you/your child gotten in trouble with the law?     Yes (5)  No (0)
6. In the last 30 days, have you/your child actively participated in enjoyable activities with family or friends (e.g. recreation, hobbies, leisure)?
   Yes (0)  No (5)
7. In the last 30 days, have you/your child had trouble getting along with other people including family and people outside the home?
   Yes (5)  No (0)
8. Do you/your child feel optimistic about the future?       Yes (0)  No (5)

Children Only:
9. In the last 30 days, has your child had trouble following rules at home or school?    Yes (5)  No (0)
10. In the last 30 days, has your child been placed in state custody (DCF criminal justice)?
    Yes (5)  No (0)

Adults Only:
11. Are you currently employed or attending school?       Yes (0)  No (5)
12. In the last 30 days, have you been at risk of losing your living situation?
    Yes (5)  No (0)

THERAPEUTIC APPROACH/EVIDENCE BASED TREATMENT USED

SYMPTOMS
(If present, check degree to which it impacts daily functioning.)

Anxiety/Panic Attacks    Mild Moderate Severe
Decreased Energy          Mild Moderate Severe
Delusions                Mild Moderate Severe
Depressed Mood           Mild Moderate Severe
Hallucinations           Mild Moderate Severe
Angry Outbursts          Mild Moderate Severe
Hyperactivity/InattN.    Mild Moderate Severe
Irritability/Mood Instability Mild Moderate Severe
Impulsivity              Mild Moderate Severe
Hopelessness             Mild Moderate Severe
Other Psychotic Symptoms Mild Moderate Severe
Other (include severity):  

LEVEL OF IMPROVEMENT TO DATE

□ Minor □ Moderate □ Major □ No progress to date □ Maintenance treatment of chronic condition

BARRIERS TO DISCHARGE

SUBMIT TO
Utilization Management Department
Phone: 1.866.864.1459 FAX 1.866.694.3649
REQUESTED AUTHORIZATION

(PLEASE CHECK OFF APPROPRIATE BOX TO INDICATE MODIFIER, IF APPLICABLE.)

FREQUENCY:

How Often Seen

INTENSITY:

# Units Per Visit

Requested Start Date for this Auth

Anticipated Completion Date of Service

RISK ASSESSMENT

Suicidal:  

None  □ Ideation  □ Planned  □ Imminent Intent  □ History of self-harming behavior

Homicidal:  

None  □ Ideation  □ Planned  □ Imminent Intent  □ History of harm to others

Safety Plan in place? (if plan or intent indicated):  

Yes  □ No

If prescribed medication, is member compliant?  

Yes  □ No

CURRENT MEASURABLE TREATMENT GOALS

FUNCTIONAL IMPAIRMENT SYMPTOMS (IF PRESENT, CHECK DEGREE TO WHICH IT IMPACTS DAILY FUNCTIONING.)

ADLs  □ □ □

Physical Health  □ □ □

Moderate  □ □ □

Severe

Mild

Work/School

Relationships

Substance Use Disorder  □ □ □

Drug(s) of Choice:

Last Date of substance use:

RISK ASSESSMENT

Suicidal:  

None  □ Ideation  □ Planned  □ Imminent Intent  □ History of self-harming behavior

Homicidal:  

None  □ Ideation  □ Planned  □ Imminent Intent  □ History of harm to others

Safety Plan in place? (if plan or intent indicated):  

Yes  □ No

If prescribed medication, is member compliant?  

Yes  □ No

CURRENT MEASURABLE TREATMENT GOALS

REQUESTED AUTHORIZATION

(PLEASE CHECK OFF APPROPRIATE BOX TO INDICATE MODIFIER, IF APPLICABLE.)

SERVICE

DATE SERVICE

FREQUENCY:

How Often Seen

INTENSITY:

# Units Per Visit

Requested Start Date for this Auth

Anticipated Completion Date of Service

Individual Therapy

Family Therapy

Group Therapy

Hypnotherapy (90880)

Telemmedicine (Q3014)

NON-PARTICIPATING PROVIDER - PLEASE INDICATE ANY ADDITIONAL CODES YOU ARE REQUESTING AUTHORIZATION FOR.

OTHER CODES REQUESTED:

☐

☐

☐

Have traditional behavioral health services been attempted (e.g. individual/family/group therapy, medication management, etc.) and if so, in what way are these services alone inadequate in treating the presenting problem?

Additional information?

PROVIDER NAME  PROVIDER SIGNATURE  DATE

Please feel free to attach additional documentation to support your request (e.g. updated treatment plan, progress notes, etc.).

SUBMIT TO

Utilization Management Department

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