Criterion #5 Service Needs/Discharge Planning Status Form

In order for this form to be processed, all blanks must be completed and legible.

Recipient Name:	Date of Birth:	Age:	Medicaid#:
Admission Date:	Decertification Date:	County of Residence:	
Type of Residence at Time of Admission:			

Section I (Complete when requesting initial authorization)

Check if Needed	Service	Service Available		If no, Anticipated Date of Availability
	Outpatient Treatment: ☐ Individual; ☐ Group; ☐ Family	Yes	No	
	Community Support/Case Management			
	Assertive Community Treatment			
	Day Treatment			
	Intensive In Home			
	Multisystemic Therapy			
	Residential Treatment Level: ☐ I, ☐ II, ☐ III, ☐ IV			
	PRTF (Psychiatric Residential Treatment Facility)			
	Psychiatric Evaluation and Medication Management			
	Respite			
	SAIOP			
	SACOT			
	Other (Identify):			
	Other (Identify):			
	Other (Identify):			

Section II (Update Information for reauthorization and discharge)

Date	Recipient Status	Service Required (Checked Above)	Steps Taken to Obtain Necessary Service	Anticipated Date of Availability

Is the patient at risk of decompensating if services are not available: ☐Yes; ☐No
Explain stating specific behaviors:

LME Signature/Title: ______________________________ Date: ____________

Print Name: ____________________ Telephone: ______________ FAX: ______________

I have reviewed this form and I am aware of the efforts that the LME is undertaking.

Hospital Name: ______________ Hospital Signature/Title: ______________ Date: ________

Rev12142010