COUNTY OF SAN MATEO
HEALTH SYSTEM

San Mateo County Managed Care Continued Authorization Request

Complete and submit prior to expiration of initial authorization. Submitting at least two weeks in advance will prevent any gaps in service as all services must be preauthorized.

Client Name_____DOB_____MH#_____

Provider Name _____Date of Request_____

County clinic/Team, if any _____

CURRENT FUNCTIONING (CHECK ALL THAT APPLY):

□ Current □ Recent decrease in functioning on a life area due to primary diagnosis
□ Current difficulty maintaining employment/schooling/living situation due to mental health symptoms*
□ On-going mental health symptoms related to primary diagnosis needing treatment
□ Current □ Recent risk -of harm to others (threats, significant ideations, violent acts)*
□ Current □ Recent risk -of harm to self (threats, significant ideations, attempts, plans)*
□ Current □ Recent risk -hallucinations, bizarre behavior, or delusional thoughts*
□ Current □ Recent risk- gravely disabled (unable to perform most daily tasks)*
□ Current □ Recent risk- Health is at significant risk due to mental health symptoms*
□ Current □ Recent Psychiatric hospitalization within the last 6 months*

*** Note: Checking any of the above risk factors may indicate the need for higher level of care. If so determined, please inform Call Center staff @ 1-800-686-0101**

CLINICAL UPDATE SINCE INITIAL ASSESSMENT DATED:_____

Include symptoms, behaviors and functional impairments: including above checked risk factors

MENTAL HEALTH DIAGNOSIS: based on client's presentation at the time of assessment; focus of clinical attention or treatment

DSM 5	ICD-10 Code	
		PRINCIPAL DX
		SECONDARY DX

CONFIDENTIAL PATIENT INFORMATION: "See California Welfare and Institutions Code Section 5328."

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Client Name_____DOB_____MH#_____

Provider Name _____Date of Request_____

PLAN START DATE | | **PLAN END DATE** | |

CLIENT'S OVERALL GOAL/DESIRED OUTCOME: *What the client wants from treatment, in client's words.*

DIAGNOSIS/PROBLEMS/IMPAIRMENTS – Signs, symptoms and behavioral problems resulting from the diagnosis that impede client from achieving desired outcome. Impairments related to the diagnosis must be addressed in all **medical necessity** goals.

GOAL - Development of new skills/behaviors and reduction, stabilization, or removal of symptoms/impairments.

OBJECTIVES - Client's next steps to achieving goal. Must be **observable, measurable and time-limited** objectives that address **symptoms/impairments** linked to the **primary diagnosis**.

INTERVENTIONS – Describe in detail the interventions proposed for each service type: Individual Therapy, Medication Support…etc. (E.g. – Clinician will provide individual therapy, utilizing cognitive-behavioral techniques, to assist client with decreasing his depressive symptoms.)

Client Signature_____ Date_____

Parent/Guardian_____ Date_____

___Copy was offered to client and accepted __Copy was offered and declined __Unable to offer Copy: See progress note dated_____

_____

PROVIDER AUTHORIZING PLAN Discipline Date

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COUNTY OF SAN MATEO
HEALTH SYSTEM

Client Name_____DOB_____MH#_____

Provider Name _____Date of Request_____

TREATMENT AUTHORIZATION REQUEST

CPT CODE	Bilingual Differential Yes/No	# of sessions Requested	Frequency	Authorization Begin Date