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

San Mateo County Behavioral Health and Recovery Services

ACCESS Team, 1950 Alameda de Las Pulgas, San Mateo, CA 94403

Phone: 1-800-686-0101 **FAX: (650) 349-0771**

Client Name _____ DOB _____ SS# ____ - ____ - ____

YOUTH Medi-Cal Managed Care Re-Authorization Request

Complete & submit after initial ten sessions to request authorization to provide ongoing MH Services.
If no changes after subsequent sessions, submit pages 7, 8, 9 & 10 to request additional authorization.

Provider _____ Therapist # _____ or Agency # _____

Phone _____ FAX _____ Check if requesting bilingual pay differential ☐

Date _____ Date Initial ACCESS Referral _____ MH # _____

Client's current address _____

Phone-Home/message _____ Cell _____ Email _____

Lives with [name and relationship] _____

Contact person _____ Contact's phone _____

Client's School [name & grade] _____ Special Ed ☐ yes ☐ no

Primary Language ☐ English ☐ Spanish ☐ Tagalog ☐ Chinese ☐ Russian ☐ Other _____

Are cultural issues involved? ☐ yes ☐ no If yes, identify _____

Does client have? Shadow ☐ yes ☐ no Case Manager ☐ yes ☐ no

IEP in place ☐ yes ☐ no GGRC Services ☐ yes ☐ no

If yes, provide name and phone number _____

Support: ☐ family involved ☐ family not involved/supportive ☐ other resources

Explain: _____

Presenting Problem(s)

Client Name _____ DOB _____ SS# ____-____-____

Previous Medications

Medication	Symptoms Addressed/focus of Medication regimen	Name and telephone number of physician prescribing this medication	Indicate if PCP or Psychiatrist

Current Medications

Medication	Symptoms Addressed/focus of Medication regimen	Name and telephone number of physician prescribing this medication	Indicate if PCP or Psychiatrist

Are you coordinating your mental health services with the client's PCP? ☐ yes ☐ no

Are you coordinating your mental health services with the client's psychiatrist? ☐ yes ☐ no

If no coordination or contact, please explain why:

Psychiatric History

	Name & Location of Hospital or Provider including discipline	Dates	Reason for Service
Psychiatric Hospitalization			
Outpatient Treatment including current services			

Client Name _____ DOB _____ SS# ____-____-____

Psychiatric History (continued)

	Name & Location of Hospital or Provider including discipline	Dates	Reason for Service
Day Program			
Substance Abuse Treatment including current services			

Medical History

Any report of:

Surgery (when & for what)	☐ yes	☐ no
Chronic Illness (includes seizures, thyroid disorder, cancer, anemia)	☐ yes	☐ no
Hospitalizations	☐ yes	☐ no
Head Trauma	☐ yes	☐ no
Major Accidents	☐ yes	☐ no
Allergies	☐ yes	☐ no
Somatic issues or complaints	☐ yes	☐ no

Provide information for each category in which 'yes' was checked _____

Primary Care Physician _____ Date of last physical exam _____

Client Name _____ DOB _____ SS# ____-____-____

Legal History

Is client currently on probation? ☐ yes ☐ no

If yes, provide information regarding arrest & conviction

Suicide Assessment

Suicide/Self-Harm	**Assessed Risk Level**				
Factors	None	Low	Moderate	High	Uncertain
Current ideation	☐	☐	☐	☐	☐
Expressed intent	☐	☐	☐	☐	☐
Specific plan	☐	☐	☐	☐	☐
Ease & means availability	☐	☐	☐	☐	☐
Access to firearms/weapons in the home	☐	☐	☐	☐	☐
Degree of perceived hopeless/helplessness	☐	☐	☐	☐	☐
Reliability of impulse control	☐	☐	☐	☐	☐
Level of detail of plans to dispense of personal belongings, after death (e.g., preparation of Last Will & Testament)	☐	☐	☐	☐	☐
Amount of and ability to use supportive resources	☐	☐	☐	☐	☐

Lethality of Prior Suicide/Self-Harm Attempts	**Assessed Risk Level**				
Describe attempt (e.g. Overdose, Accident . . .)	None	Low	Moderate	High	Uncertain
1.	☐	☐	☐	☐	☐
2.	☐	☐	☐	☐	☐
3.	☐	☐	☐	☐	☐

Client Name _____ DOB _____ SS# ____-____-____

Current Psychosocial Stressors (Briefly identify or describe stressor in appropriate area)

	None/Mild	Moderate	Severe	Undetermined
Family Problems	☐	☐	☐	☐
Social/Interpersonal	☐	☐	☐	☐
Financial	☐	☐	☐	☐
Exposure to Trauma	☐	☐	☐	☐
Housing	☐	☐	☐	☐
School	☐	☐	☐	☐
Work	☐	☐	☐	☐

Additional Information About Psychosocial Stressors

Have you reviewed all available school records, including psychological examinations?	☐ yes	☐ no
Have you had on-going, regular contact with client's teacher/s?	☐ yes	☐ no
Have you had on-going and regular contact with the client's school psychologist?	☐ yes	☐ no
Is the client being considered for EC 26.5/AB 3632 referral?	☐ yes	☐ no
Have you completed a detailed developmental history of the child and made referrals for necessary diagnostic evaluations (e.g., hearing, speech, vision, genetic, D&A)	☐ yes	☐ no

Explain all areas checked 'no' above

Client Name _____ DOB _____ SS# _____ - _____ - _____

Child or Youth's Strengths and Family/Support System Resources

Client Name _____ DOB _____ SS# ____-____-____

Specific Symptoms & Behaviors

		Status of Symptoms				
Symptom	Date of Onset	None Resolved	Mild Seldom	Moderate Sporadic	Severe Frequent	Check if focus of treatment during this authorization period & if medication utilized
Sleep Disturbance		☐	☐	☐	☐	☐ Focus ☐ Medication
Appetite Disturbance		☐	☐	☐	☐	☐ Focus ☐ Medication
Irritability		☐	☐	☐	☐	☐ Focus ☐ Medication
Anxiety or Panic		☐	☐	☐	☐	☐ Focus ☐ Medication
Depression		☐	☐	☐	☐	☐ Focus ☐ Medication
Bizarre Behavior		☐	☐	☐	☐	☐ Focus ☐ Medication
Compulsions/Obsessions		☐	☐	☐	☐	☐ Focus ☐ Medication
A/V Hallucinations		☐	☐	☐	☐	☐ Focus ☐ Medication
Delusions		☐	☐	☐	☐	☐ Focus ☐ Medication
Suicidal Ideation		☐	☐	☐	☐	☐ Focus ☐ Medication
Homicidal/Assault Ideas		☐	☐	☐	☐	☐ Focus ☐ Medication
Violence Towards Self/Others		☐	☐	☐	☐	☐ Focus ☐ Medication
Destruction of Property		☐	☐	☐	☐	☐ Focus ☐ Medication
Other		☐	☐	☐	☐	☐ Focus ☐ Medication

If Other is check, please describe symptoms: _____

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Substance Abuse Use

			Status of Current Usage				
Substance	Age when Use Began	Check if Family History	None or Resolved	Mild Seldom	Moderate Sporadic	Severe Frequent	Focus of Treatment
Alcohol		☐	☐	☐	☐	☐	☐
Amphetamines		☐	☐	☐	☐	☐	☐
Cocaine		☐	☐	☐	☐	☐	☐
Opiates		☐	☐	☐	☐	☐	☐
Sedatives		☐	☐	☐	☐	☐	☐
PCP		☐	☐	☐	☐	☐	☐
Hallucinogens		☐	☐	☐	☐	☐	☐
Inhalants		☐	☐	☐	☐	☐	☐
Marijuana		☐	☐	☐	☐	☐	☐
Prescription Abuse		☐	☐	☐	☐	☐	☐
Tobacco		☐	☐	☐	☐	☐	☐

Diagnosis and Treatment Related Issues

Use **P**&**S** to specify one **P**rimary and one **S**econdary Mental Health Diagnosis

DSM5	ICD10-Code	P/S

Other Factors Significantly Affecting Mental Health			
Substance Abuse (if yes, specify in an Axis I Diagnosis)	☐ yes	☐ no	☐ unknown
Developmental Disabilities	☐ yes	☐ no	☐ unknown
Physical Health Disorders (specify below)	☐ yes	☐ no	☐ unknown

Treatment Plan to reduce impairment and risks – targets must coordinate with diagnosis

Target Behavior	Intervention	Target Date	New or Continuing Goal
1.			
2.			
3.			
4.			
5.			
6.			

Current medication regimen _____

Client Name _____ DOB _____ SS# ____ - ____ - ____

Parent/Guardian Acknowledgement of Treatment Plan

I have read this treatment plan document and understand its contents. I consent to the services recommended.

_____ _____ _____ _____

Parent's Signature | Date | Legal Guardian's Signature | Date

Treatment Authorization Requested Check box if requesting bilingual pay differential ☐

CPT Code	Frequency Requested (e.g., weekly, 2x month, etc.)	Sessions (<26)	Start Date	End Date

_____ _____ _____ _____

Provider Name, typed or printed | Discipline | License # | Signature

_____ _____ _____

Provider Agency, if applicable | Provider Office Phone | Provider Fax Number

FOR ACCESS USE ONLY – DO NOT WRITE BELOW THIS LINE

ACCESS Authorization Decision

Add bilingual pay differential ☐

CPT Code	Frequency state	Sessions (<26)	Start Date	End Date

Date of Auth _____ Initials _____ NOA Sent ☐ yes ☐ no Chart Located ☐ yes ☐ no