SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

# 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_____

PROVIDER TELEPHONE_____COUNTY CLINIC IF ANY_____

**CURRENT FUNCTIONING (CHECK ALL THAT APPLY):**

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|---|
| □ 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 contact Call Center staff at 1-800-686-0101.**

**CLINICAL UPDATE SINCE INITIAL ASSESSMENT DATED: _____**

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

| |
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| |

**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 |
| | | |

**PROVIDER SIGNATURE** _____**LICENSE NO.**_____ **DATE**_____

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



**Fax to 650-596-8065 or mail to Access Call Center – 310 Harbor Blvd., Bldg. E, Belmont, CA 94002**

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## MANAGED CARE CONTINUED AUTHORIZATION REQUEST

Confidential Patient Information: See California Welfare and Institutions Code Section 5328

CLIENT NAME_____MH#_____DOB_____

PROVIDER NAME_____PROVIDER TELEPHONE #_____

# CLIENT TREATMENT AND RECOVERY PLAN

*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.*

**PLAN START DATE** | **PLAN END DATE (1 yr.max)**

**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 Signature:_____Date_____

Provider Signature: _____ License No._____Date _____

Copy offered to client/accepted, Copy offered/declined, Unable to offer Copy-See prog. note dated_____



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# MANAGED CARE CONTINUED AUTHORIZATION REQUEST

Confidential Patient Information: See California Welfare and Institutions Code Section 5328

CLIENT NAME_____MH#_____DOB_____

PROVIDER NAME_____PROVIDER TELEPHONE #_____

## TREATMENT AUTHORIZATION REQUEST

| CPT Code | Bilingual Differential Yes/No | Number of Services | Frequency | Authorization Begin Date |
|---|---|---|---|---|
| | | | | |
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