Banner
University Family Care

OUT-OF-HOME (OOH) APPLICATION

This request is to be completed (typed) and submitted with the Behavioral Health Prior Authorization.

Send by Fax to:

BUHP Behavioral Health Prior Authorization Department at (520) 694-0599.

This form must be accompanied by the Behavioral Health Prior Authorization Form.

All fields must be filled out. Incomplete or handwritten forms will be returned to sender.

Date of Request:_____ **Request for:** Adult ☐ Child/Adolescent ☐

Request: ☐ Behavioral Health Residential Facility (BHRF) ☐ Therapeutic Foster Care/Adult BH Therapeutic Home

☐ Behavioral Health Inpatient Facility (BHIF/RTC)

Member's Name:_____ **Age:**____ **DOB:**_____

AHCCCS ID: _____ **Gender:** _____

Member's Primary Language: ☐ English ☐ Spanish ☐ Other (specify): _____

Legal Status (Adults only) ☐ COT ☐Voluntary

Are all ART/CFT members in agreement of this level of care? ☐ Yes ☐ No

Behavioral Health Category: ☐ GMH ☐ SU ☐ Child **Funding Source:** ☐ T19 ☐ T21

Where is the member currently living? ☐ Home ☐ DOC ☐ House ☐ Jail ☐ Respite ☐ Shelter

☐ Other: _____

If other than home – admission date: _____

Facility: _____

Name of the proposed OOH Facility: _____

Address: _____

Further information can be found on the Behavioral Health Comprehensive Provider Manual Supplement

If applicable

Legal guardian: _____ **Phone #:** _____ **Ext:** _____

Fax #: _____

Street address: _____ **City:** _____

State: _____ **Zip Code:** _____

Legal guardian's primary language: ☐ English ☐ Spanish ☐ Other (specify): _____

Requesting Outpatient Provider Agency: _____

Name of person completing request: _____ **Phone #:** _____ **Ext:** _____

Staff email: _____ **Fax #:** _____

Clinical Director Name: _____

Signature: _____ **Date:** _____

Why is an out of home intervention being requested at this time?

Who will be involved with member's treatment? Family, friends, supports

What outpatient services have been tried? CHECK ALL THAT APPLY.

☐ None	☐ Home-based therapy	☐ Peer support
☐ Behavior Coach	☐ Independent living skills	☐ Respite
☐ Crisis stabilization team	☐ Individual counseling	☐ Skills training and development
☐ Dialectical Behavior Therapy (DBT)	☐ Medication management	☐ Substance abuse IOP
☐ Family counseling	☐ Other in-home services	☐ Vocational assessment & training
☐ Functional Behavioral Analysis (FBA)	☐ Parent partner	☐ Other:

Further information can be found on the Behavioral Health Comprehensive Provider Manual Supplement

Measurable Goals for this Out of Home Admission:

Specify the SMART goals the member will accomplish at the treatment facility. (Specific, Measurable, Achievable, Relevant and Time Based)

Goal:	Objectives:

Required documentation checklist for OOH Admission request: (to be included)

****Please note: OOH request will not be reviewed without the following documentation. ****

☐ ART/CFT notes for the past 30 days

☐ ASAM if request is for OOH substance abuse treatment

☐ Current Complete Care Plan (must be updated with requested service identified in the plan)

☐ Most recent psychiatric evaluation or psychiatric progress note and medication notes

☐ Psychiatric progress notes for the last 30 days

☐ Medical/physical status/orders/progress notes, (including rationale for personal care services)