

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.

All fields must be filled out. Incomplete or handwritten forms will be returned to sender.				
Date of Request:	Request for: Adult \square Child/Adolescent \square			
Request: \square Behavioral Health Residential Facility (BHRF) \square Home Care Training to Home Care Client (HCTC)				
☐ Behavioral Health Inpatie	nt Facility (BHIF/RTC)			
Member's Name:		Age:	DOB:	Gender:
AHCCCS ID:				
Member's Primary Language: ☐ English ☐ Spanish ☐ Other (specify):				
Legal Status (Adults only) \square COT \square V	oluntary			
Are all ART/CFT members in agreemen	nt of this level of care? \Box	Yes □ No		
Behavioral Health Category: ☐ GMH ☐ SU ☐ Child		Funding Source: ☐ T19 ☐ T21		
Where is the member currently living? \square Home \square DOC \square House \square Jail \square Respite \square Shelter				
	☐ Other:			
	If other than home – adm	nission date	e:	
	Facility:			
Name of the proposed OOI	H Facility:			
Address:				

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

If applicable Legal guardian: Phone #: Ext: 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. ☐ Peer support ☐ Home-based therapy ☐ None ☐ Respite ☐ Independent living skills ☐ Behavior Coach

☐ Functional Behavioral Analysis (FBA)

☐ Dialectical Behavior Therapy (DBT)

☐ Crisis stabilization team

☐ Family counseling

☐ Skills training and development

☐ Substance abuse IOP

☐ Vocational assessment & training

☐ Other:

☐ Parent partner

☐ Individual counseling

☐ Medication management

☐ Other in-home services

Measurable Goals for this Out of Home Admission:		

Specify the SMART goals the member will accomplish at the treatment facility.

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			
\square ASAM if request is for OOH substance abuse tr	reatment		
☐ 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			
$\hfill\Box$ Psychiatric progress notes for the last 30 days			
☐ Medical/physical status/orders/progress notes	s, (including rationale for personal care services)		

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