

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 Child/Adolescent

Request: Behavioral Health Residential Facility (BHRF) Home Care Training to Home Care Client (HCTC)
 Behavioral Health Inpatient Facility (BHIF/RTC)

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

AHCCCS ID: _____

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: _____

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.

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

Measurable Goals for this Out of Home Admission:

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

Target Behavior

Goal

Target Behavior	Goal
Example: Decrease craving to low	A substance free lifestyle

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)