

- Initiate CMH Program services
- Service Modification
 - Add a service
 - Increasing level/hours of service
 - Decreasing level/hours of service
- Change in Provider (requires 2 ISARs)
- End a service

Case Management/Transition
Coordination agency

CMH Program Therapeutic Consultation Services Individual Service Authorization Request

Provider # _____

Provider Name _____

Provider Number _____

Name: _____

Last,

First

MI

Start Date: _____

End Date: _____

Medicaid Number: _____

Only Behavioral Consultation may be provided in the absence of other CMH Program services.

SERVICE TO BE PROVIDED

HOURS NEEDED

DMAS USE ONLY

97139 Therapeutic Consultation <input type="checkbox"/> Behavioral <input type="checkbox"/> Psychological <input type="checkbox"/> Speech/OT/Physical Rehab <input type="checkbox"/> Recreational <input type="checkbox"/> Rehabilitation Engineering <input type="checkbox"/> Other		
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Reason for the request: _____

Check the allowable activities that are included in the client's plan. Indicate the approximate total number of hours.

(May not be direct therapy, evaluations, or services available through the Medicaid State Plan.)	Hours needed in each area
Assessment/evaluation: <input type="checkbox"/> interviewing to identify issues to be addressed/desired outcomes <input type="checkbox"/> observing in daily activities and natural environments <input type="checkbox"/> assessing need for assistive device or modification/adjustment in environment or services <input type="checkbox"/> developing data collection mechanisms and collecting baseline data <input type="checkbox"/> observing & assessing current interventions, support strategies, or assistive devices/ environmental modifications <input type="checkbox"/> reviewing documentation & evaluating efficacy of assistive device or interventions suggested	
Training, consultation & technical assistance to program staff/family: <input type="checkbox"/> training in better supporting the client through enhanced observations of environment/routines/interactions <input type="checkbox"/> reviewing documentation & evaluating staff/family activities <input type="checkbox"/> demonstrating/training in specialized therapeutic interventions or use of assistive devices/ environmental modifications	
Assistance in design & integration of individual objectives as part of the overall individual program planning process: <input type="checkbox"/> designing & developing a written Behavior Plan or Individual Service Plan <input type="checkbox"/> making recommendations related to specific devices/technology or adapting other training programs/activities	
Comments: _____ _____ _____	

Name of Provider Agency Representative (print)

Signature

Date

I agree that the above plan of services is appropriate to the identified needs of this client. This service plan has been approved by the client and family/caregiver, as appropriate, and included in the CSP maintained in the transition coordination/case management record.

Transition Coordinator/Case Manager (print)

Signature

Phone No.

Fax No.

Date

DMAS 811