ASSERTIVE COMMUNITY TREATMENT AUTHORIZATION FORM

Member name: _____

Member ID: _____

Date of request: _____

Intended or actual date of initiation of service: _____

Date of birth: _____ Diagnosis (ICD10): _____

Provider name/agency: _____ Tax ID: _____

Contact name: _____

Contact phone number: _____

Address: _____

The provider is referred to The Health Plan's policy regarding authorization of ACT services which may be found on The Health Plan's website at healthplan.org *under "For Providers."*

Initial Authorization Requirements

Please check any that may apply and supply dates of hospitalization/inpatient treatment:

☐ Three or more hospitalizations in a psychiatric inpatient unit or psychiatric hospital in the past 12 months

Dates of hospitalization/inpatient treatment: _____

☐ Five or more hospitalizations in a psychiatric inpatient unit, psychiatric hospital, or Community Psychiatric Supportive Treatment Program in the past 24 months

Dates of hospitalization/inpatient treatment: _____

☐ 180 days total length of stay in a psychiatric inpatient unit or psychiatric hospital within the past 12 months

Dates of hospitalization/inpatient treatment: _____

Other possible extenuating criteria (please check):

☐ Homelessness
☐ Frequent arrests
☐ Co-occurring SUD
☐ Mild ID/DD
☐ Frequent misuse of emergency departments

Describe significant functional impairments due to mental illness as demonstrated by at least one of the following:

a. Significant difficulty performing a range of daily living tasks required to function in the community (e.g. caring for personal business; obtaining medical, legal and housing services; recognizing and avoiding common dangers or hazards to self and others; meeting nutritional needs; maintaining personal hygiene)

b. Difficulty in treatment adherence (e.g. keeping appointments or medication adherence)

c. Unstable housing (e.g. repeated evictions or loss of housing) and/or recent history of criminal justice involvement due to mental health symptomology

Continued Stay Authorization

The provider must include the following attachments in any request for continued stay for ACT:

- Weekly assessments for period since last authorization date (dated)
- Current treatment plan
- Most recent 90-day treatment review
- List of current medications.

The treatment plan must address the issues related to identified functional impairments and how they are being addressed by the team. The plan must also reflect modification based upon lack of progress as well as addition to the plan created by new/emerging issues and resolution of completed objectives.

Submit authorization/initiation of service requests to:

The Health Plan

Phone: 1.800.624.6961

Fax: 1.866.616.6255