

CareOregon Level of Care Authorization Form

Child and Adolescent Mental Health Services Initial Treatment Registration Form



Member Information

Member name: _____ OHP ID: _____

Date of birth: _____

Provider: _____ Location: _____

Service period start date: _____ End date: _____

Admission LOC requested

A B C D, ages 0-5 D, ages 6-17

Admission Clinical Criteria *(please check all that apply)*

Level A

Covered diagnosis on the prioritized list

AND

The need for maintenance of a medication regimen (at least quarterly) that cannot be safely transitioned to a PCP

OR

A mild or episodic parent-youth or family system interactional problem that is triggered by a recent transition or outside event and is potentially resolvable in a short period of time

OR

Transitioning from a higher level of service (step down) in order to maintain treatment gains and has been stable at his level of functioning for three to four visits

AND

Low acuity of presenting symptoms and minimal functional impairment

AND

Home, school, community impact is minimal

Last Updated: November 2019

<p>Level B</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Covered diagnosis on the prioritized list <p>AND</p> <ul style="list-style-type: none"> <input type="checkbox"/> Mild to moderate functional impairment in at least one area (for example, sleep, eating, self-care, relationships, school behavior or achievement) <p>OR</p> <ul style="list-style-type: none"> <input type="checkbox"/> Mild to moderate impairment of parent/child relationship to meet the developmental and safety needs <p>OR</p> <ul style="list-style-type: none"> <input type="checkbox"/> Transition from a higher level of service intensity (step-down) to maintain treatment gains
<p>Level C</p>	<p>Criteria for early childhood and school-age and adolescents:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Covered diagnosis on the prioritized list <p>AND at least one of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Significant risk of harm to self or others <input type="checkbox"/> Moderate to severe impairment of parent/youth relationship to meet the developmental and safety needs <input type="checkbox"/> Moderate to severe functional or developmental impairment in at least one area <p>AND for school-age children and adolescents at least one of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Risk of out-of-home placement or has had multiple transition in placement in the last six months due to symptoms of mental illness <input type="checkbox"/> Risk of school or daycare placement loss due to mental illness or development needs <input type="checkbox"/> Multiple system involvement requiring coordination and case management <input type="checkbox"/> Moderate to severe behavioral issues that cause chronic family disruption <input type="checkbox"/> Extended crisis episode requiring increased services <input type="checkbox"/> Recent acute or subacute admission (within the last six months) <input type="checkbox"/> Significant current substance abuse for which integrated treatment is necessary <input type="checkbox"/> Transition from a higher level of service intensity (step-down) to maintain treatment gains <input type="checkbox"/> Youth and/or family's level of English language skill and/or acculturation is not sufficient to achieve symptom or functional improvement without case management

<p>Level D Early childhood, ages 0-5</p>	<p>ALL must be met:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Covered diagnosis on the prioritized list <input type="checkbox"/> Current serious to severe functional impairment in multiple areas <input type="checkbox"/> Treatment intensity at a lower level of care insufficient to maintain functioning <p>AND four of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Serious risk of harm to self or others due to symptoms of mental illness (e.g., impulsivity resulting in elopement, aggression, sexualized behaviors, expressed intent to harm self or others, etc.) <input type="checkbox"/> Serious impairment of caregiver capacity to meet the developmental and safety needs of their child (e.g., parent in substance abuse treatment, domestic violence, mental illness, etc.) <input type="checkbox"/> Significant risk of disruption from current living situation due to child’s symptoms related to a mental health diagnosis <input type="checkbox"/> Significant cultural and language barriers impacting ability to fully integrate symptom management skills and there is not more clinically appropriate service <input type="checkbox"/> Multiple recent placement changes for child resulting in increase in emotional/ behavioral dysregulation <input type="checkbox"/> Current significant risk of losing daycare or early childhood education placement due to behaviors related to mental health symptoms or trauma (e.g., sexualized behavior, increased arousal, persistent negative emotional state, biting, extreme tantrums, etc.)
<p>Level D Home- based stabilization, ages 6-17</p>	<p>BOTH must be met:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Covered diagnosis on the prioritized list <input type="checkbox"/> Current serious to severe functional impairment in multiple areas <p>AND one of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Treatment intensity at a lower level of care insufficient to maintain functioning <input type="checkbox"/> Hospital or subacute admission in the last 30 days <p>AND two of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Serious risk of harm to self or others due to symptoms of mental illness <input type="checkbox"/> Serious impairment of parent/youth relationship to meet the developmental and safety needs <input type="checkbox"/> Significant risk of disruption from current living situation due to symptoms related to a mental health diagnosis <input type="checkbox"/> Transition from a higher level of service intensity (step down) to maintain treatment gains <input type="checkbox"/> Significant cultural language barriers impacting ability to fully integrate symptom management skills and there is not more clinically appropriate service available

Clinically Assessed Level of Care

Level A

Level B

Level C

Level D

Level of Care Assigned

(Optional: Only needed if LOC assigned is different from clinically assessed LOC)

Level A

Level B

Level C

Level D

Justification for assigned level of care

(Optional: Only needed if LOC assigned is different from clinically assessed LOC)

Please describe the reason for the client's assigned level of care

Plan for engagement

(Optional: Only needed if LOC assigned is different from clinically assessed LOC)

Please describe how you will engage the client in clinically indicated level of care

I attest that the information contained herein accurately reflects the clinical presentation of the client. I understand that additional clinical information may be requested or a retroactive chart review may be completed to ensure the clinical presentation is as represented above.

Clinician signature: _____

Printed name: _____ Date: _____

Supervisor signature[†]: _____

Printed name: _____ Date: _____

[†]Supervisor signature is not required but encouraged if reviewed together through clinical supervision.