



Phone: 888-510-1150 ext.292621
 Fax : 919-461-9645

***Please write legibly and complete all areas that apply. Application will not be processed without it.**

Criterion #5 Service Needs/Discharge Planning Status Form

Client Name: (Last, First, Middle Initial)	Date of Birth:	Age:	Medicaid#
			Area Program#
Admission Date:	Decertification Date:	LME:	County:

Complete when requesting initial authorization

Check if Needed	Services	Available Yes No		If No, Anticipated Date of Availability
<input type="checkbox"/>	Outpatient Treatment <input type="checkbox"/> Individual <input type="checkbox"/> Group			
<input type="checkbox"/>	Case Management			
<input type="checkbox"/>	Community Based Service (CBS)			
<input type="checkbox"/>	Assertive Community Treatment			
<input type="checkbox"/>	Day Treatment			
<input type="checkbox"/>	Residential Treatment Level I			
<input type="checkbox"/>	Residential Treatment Level II			
<input type="checkbox"/>	Residential Treatment Level III			
<input type="checkbox"/>	Residential Treatment Level IV			
<input type="checkbox"/>	PRTF			
<input type="checkbox"/>	Psychiatric Evaluation and Treatment			
<input type="checkbox"/>	Respite			
<input type="checkbox"/>	Other			

Date/Client Status	Service(s) Needed	Steps Taken by Area Program to Provide Needed Service	Anticipated Availability Date

Is the patient at risk of decompensation if services are not available: Yes No

Explain stating specific behaviors:

Signature/Title (Area Program) Date

() _____ () _____

Phone # Fax#

Name/Title (Area Program) Date

Please Print

I have reviewed this form and I am aware of the efforts that the Area Program is undertaking.

Hospital: _____

Signature/Title (Hospital Discharge Planner) Date