The Illinois Mental Health Collaborative for Access and Choice
REQUEST FOR AUTHORIZATION OF
ADULT COMMUNITY SUPPORT TEAM SERVICES (CST)
☐ **Initial Request (CST) -or-** ☐ **Reauthorization Request (CST)**

☐ **ENHANCED SKILLS TRAINING (EST)**
☐ **IN-HOME RECOVERY SUPPORT (IHR)**

NOTE: Reauthorizations are not permitted for EST and IHR Services

Agency: _____ **Name of Referred:** _____
Agency Location: _____ **Date of Birth:** _____
Agency FEIN: _____ **RIN#:** _____
Team Name: _____

Male: ☐ **Female:** ☐ **Date CST Service Started:** _____

PLEASE PRINT (Must Include)
Staff to contact with any CLINICAL questions: _____
Phone: _____ **Secure Fax Number:** _____
Encrypted Email Address: _____

PLEASE PRINT (must include)
Staff to contact with any REGISTRATION questions: _____
Phone: _____ **Secure Fax Number:** _____
Encrypted Email Address: _____

Current Medications: (Name, Dose, Frequency)

Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____
Name: _____ Dose: _____ Frequency: _____

I. SERVICE DEFINITION CRITERIA (Please check all that apply)

☐ Multiple and frequent psychiatric inpatient admissions;
☐ Excessive use of crisis or emergency services with failed linkages;
☐ Chronic homelessness;
☐ Repeat arrests and incarcerations;
☐ History of inadequate follow-through with elements of an ITP related to risk factors, including lack of follow through taking medications, following a crisis plan, or achieving stable housing;
☐ High use of detoxification services (e.g., two (2) or more episodes per year);
☐ Clinical evidence of suicidal ideation or behavior in last three (3) months;
☐ Ongoing inappropriate public behavior within the last three months including (but not limited to) such examples as public intoxication, indecency, disturbing the peace;
☐ Self harm or threats of harm to others within the last three (3) months;
☐ Medication resistance due to: intolerable side effects or illness-mediated interference with consistent self-management of medications;

Agency: _____ **RIN#:** _____

☐ Evidence of significant complications such as cognitive impairment, behavioral problem or medical problems;

☐ *For Youth Only:* Child and/or family behavioral health issues that have not shown improvement in traditional outpatient settings and require coordinated clinical and supportive interventions.

☐ *For Youth Only:* Because of behavioral health issues, the child or adolescent has shown risk of out-of-home placement or is currently in out-of-home placement and reunification is imminent.

II. DIAGNOSIS

PRIMARY BEHAVIORAL DIAGNOSIS (DSM-5) ***Required Field**

*Diagnostic Category 1	*Diagnosis Code 1	*Description

ADDITIONAL BEHAVIORAL DIAGNOSIS (DSM-5)

Diagnostic Category 2	Diagnosis Code 2	Description
Diagnostic Category 3	**Diagnosis Code 3**	**Description**
Diagnostic Category 4	**Diagnosis Code 4**	**Description**
Diagnostic Category 5	**Diagnosis Code 5**	**Description**

PRIMARY MEDICAL DIAGNOSIS (DSM-5) ***Required Field**

*Diagnostic Category 1	Diagnosis Code 1	Description
Diagnostic Category 2	**Diagnosis Code 2**	**Description**
Diagnostic Category 3	**Diagnosis Code 3**	**Description**

SOCIAL ELEMENTS IMPACTING DIAGNOSIS (DSM-5) ***Check all that apply (Required)**

☐ **None**	☐ **Problems with access to health care services**	☐ **Housing Problems (Not Homelessness)**	☐ **Problems related to the social environment**
☐ **Educational problems**	☐ **Problems related to interaction w/legal system/crime**	☐ **Occupational problems**	☐ **Homelessness**

☐ **Financial Problems**	☐ **Problems with primary support group**	☐ **Medical disabilities that impact diagnosis or must be accommodated for in treatment**	☐ **Unknown**
☐ **Other psychosocial and environmental problems**			

FUNCTIONAL ASSESSMENT (DSM-5) Required

Assessment Measure	Assessment Score	Secondary Assessment Measure	Assessment Score
☐ **GAF** ☐ **CGAS**		☐ **Not Applicable**	

III. FUNCTIONAL IMPAIRMENT (**MUST Complete all domains from the LOCUS tool)**

DOMAIN SCORES:

Risk of Harm: _____

Recovery Environment-Environmental Stressors: _____

Reason(s) for Recovery Environmental Stressors Rating (MUST Check all that apply):

- ☐ **Level of disruption in family or social milieu**
- ☐ **Life transition-such as loss of job, loss of home**
- ☐ **Status of physical health**
- ☐ **Dangers in or near habitat**
- ☐ **Access to drugs and alcohol**
- ☐ **Ability to meet obligations in a timely manner**

Recovery Environment-Environmental Support: _____

Functional Status: _____

Reason(s) for Functional Status Rating (MUST Check all that apply):

- ☐ **Interpersonal interactions**
- ☐ **Social interaction impairment**
- ☐ **Personal hygiene**
- ☐ **Disturbance in physical functioning**
- ☐ **Ability to maintain personal responsibilities**

Co-morbidity: _____

Recovery and Treatment History: _____

Acceptance and Engagement: _____

Reason(s) for Acceptance and Engagement Rating (MUST Check all that apply):

- ☐ **Understanding and acceptance of illness**
- ☐ **Ability to utilize available resources**
- ☐ **Understanding of recovery process**
- ☐ **Involvement in recovery process**

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RIN#: _____ **Name of Referred:** _____

LOCUS RECOMMENDED LEVEL OF CARE: **Composite Score:** _____

☐ Level I ☐ Level II ☐ Level III ☐ Level IV ☐ Level V ☐ Level VI

ASSESSOR RECOMMENDED LEVEL OF CARE (In accordance with services crosswalk)

☐ Level I ☐ Level II ☐ Level III ☐ Level IV ☐ Level V ☐ Level VI

Reason for Deviation (If Applicable)
Explain:

IV. OHIO SCALE RESULTS:

Worker Ohio problem severity scale (0-100):_____

PLEASE INCLUDE THE FOLLOWING DOCUMENTS WITH THIS REQUEST FORM:
(Indicate documents are included by checking)

☐ Mental Health Assessment (Current)
☐ Individual Treatment Plan (Current)
☐ Consumer's Crisis Plan
☐ Resident Reviewer's Recommendation for Enhanced Service(s)

V. TRANSITION PLAN NARRATIVE – If applicable (Please write legibly)
This section is to be used when CST authorization is requested as part of a transition plan. *Please describe the clinical need for the transition to less intensive services or more intensive services (such as ACT)*

Describe contacts already made to facilitate the transition:

Describe issues that need to be addressed before transition can occur etc:

List additional services that are clinically indicated:

TRANSITION START DATE: _____ **TRANSITION END DATE:** _____

PLEASE NOTE THAT INCOMPLETE FORMS WILL BE RETURNED

FOR REAUTHORIZATION REQUEST: The medical necessity for this Request for Authorization and the attached Treatment Plan is recommended by an LPHA and is based upon a completed Comprehensive Mental Health Assessment which is in the consumer's clinical record and available upon request. ☐ YES

FAX REQUEST FORM TO THE COLLABORATIVE AT: (866) 928-7177)