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| **Member Information** |
| Member Name:       OHP ID: |
| Date of Birth: |
| Provider:       Location: |
| Service Period Start Date:       End Date: |
| Admission LOC Requested: A B C D |

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| **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-child 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 3-4 visits **AND**  Low acuity of presenting symptoms and minimal functional impairment **AND**  Home, school, community impact is minimal |
| Level B | Covered diagnosis on the prioritized list **AND**  Mild to Moderate functional impairment in at least one area (for example, sleep, eating, self-care, relationships, school behavior or achievement) **OR**  Mild to Moderate impairment of parent/child relationship to meet the developmental and safety needs **OR**  Transition from a higher level of service intensity (step-down) to maintain treatment gains |
| Level C | **Criteria for Early Childhood and School-Age and Adolescents:**  Covered diagnosis on the prioritized list  **At least one of the following:**  Significant risk of harm to self or others  Moderate to severe impairment of parent/child relationship to meet the developmental and safety needs  Moderate to severe functional or developmental impairment in at least one area,  **AND**  **For School-Age and Adolescents at least one of the following:**  Risk of out of home placement or has had multiple transition in placement in the last 6 months due to symptoms of mental illness  Risk of school or daycare placement loss due to mental illness or development needs.  Multiple system involvement requiring coordination and case management  Moderate to severe behavioral issues that cause chronic family disruption  Extended crisis episode requiring increased services;  Recent acute or subacute admission (within the last 6 months)  Significant current substance abuse for which integrated treatment is necessary  Transition from a higher level of service intensity (step-down) to maintain treatment gains |
| Level D | **Both must be met:**  Covered diagnosis on the prioritized list  Current serious to severe functional impairment in multiple areas  **And one of the following:**  Treatment intensity at a lower level of care insufficient to maintain functioning  Hospital or subacute admission in the last 30 days  **And two of the following:**  Serious risk of harm to self or others due to symptoms of mental illness  Serious impairment of parent/child relationship to meet the developmental and safety needs  Significant risk of disruption or disruption from current living situation  Transition from a higher level of service intensity (step-down) to maintain treatment gains  Child and/or family's level of English language and/or acculturation is not sufficient to achieve symptom or functional improvement without case management |

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| **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 retro-active 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.