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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.