# Criterion #5 Service Needs/Discharge Planning Status Form

**In order for this form to be processed, all blanks must be completed and legible.**

| | | | |
|---|---|---|---|
| Recipient Name: | Date of Birth: | Age: | Medicaid#: |
| Admission Date: | Decertification Date: | County of Residence: | |
| Type of Residence at Time of Admission: | | | |

**Section I (Complete when requesting initial authorization)**

| Check if Needed | Service | Service Available | | If no, Anticipated Date of Availability |
|---|---|---|---|---|
| ☐ | Outpatient Treatment: ☐ Individual; ☐ Group; ☐ Family | **Yes** | **No** | |
| ☐ | Community Support/Case Management | ☐ | ☐ | |
| ☐ | Assertive Community Treatment | ☐ | ☐ | |
| ☐ | Day Treatment | ☐ | ☐ | |
| ☐ | Intensive In Home | ☐ | ☐ | |
| ☐ | Multisystemic Therapy | ☐ | ☐ | |
| ☐ | Residential Treatment Level: ☐ I, ☐ II, ☐ III, ☐ IV | ☐ | ☐ | |
| ☐ | PRTF (Psychiatric Residential Treatment Facility) | ☐ | ☐ | |
| ☐ | Psychiatric Evaluation and Medication Management | ☐ | ☐ | |
| ☐ | Respite | ☐ | ☐ | |
| ☐ | SAIOP | ☐ | ☐ | |
| ☐ | SACOT | ☐ | ☐ | |
| ☐ | Other (Identify): | ☐ | ☐ | |
| ☐ | Other (Identify): | ☐ | ☐ | |
| ☐ | Other (Identify): | ☐ | ☐ | |

**Section II (Update Information for reauthorization and discharge)**

| Date | Recipient Status | Service Required (Checked Above) | Steps Taken to Obtain Necessary Service | Anticipated Date of Availability |
|---|---|---|---|---|
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Is the patient at risk of decompensating if services are not available: ☐ Yes; ☐ No
Explain stating specific behaviors:

LME Signature/Title: _____ Date: _____

Print Name: _____ Telephone: _____ FAX: _____

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

Hospital Name: _____ Hospital Signature/Title: _____ Date: _____

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