

**MODEL COMMUNITY-BASED BEHAVIORAL HEALTH SERVICES
APPROPRIATENESS DETERMINATION FORM**

1. Identifying Information:

Client name: _____ CSA ID No: _____ Date of FAPT: _____ DOB: _____

2. Specific Services Requested (check all that apply):

Intensive In-Home Services: _____

Mental Health Skill-Building Services: _____

Therapeutic Day Treatment: _____

3. Clinical Necessity Criteria (Complete for each requested service)

A. Intensive In-Home Services.

Individuals must demonstrate a clinical necessity arising from a mental, behavioral, or emotional illness which results in significant functional impairments in major life activities. Individuals must meet at least two of the following criteria on a continuing or intermittent basis:

- _____ Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization or out-of-home placement because of conflicts with family or community.
- _____ Exhibit such inappropriate behavior that repeated interventions by the mental health, social services, or judicial system are necessary.
- _____ Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior. For example, is at risk for acting in such a fashion that will cause harm to themselves or others.

B. Mental Health Skill-Building Services.

Individuals younger than 21 years of age must meet all of the following criteria in order to be eligible to receive mental health skill-building services:

- _____ The individual shall be in an independent living situation or actively transitioning into an independent living situation. (If the individual is transitioning into an independent living situation, services shall only be authorized for up to six months prior to the date of transition).
- _____ The individual shall have one of the following as a primary, Axis I DSM diagnosis:
 - a) Schizophrenia or other psychotic disorder as set out in the DSM;
 - b) Major Depressive Disorder, Recurrent; Bipolar-I; or Bipolar II, or;
 - c) Any other Axis I mental health disorder that a physician has documented specific to the identified individual within the past year to include all of the following: (i) that is a serious illness; (ii) that results in severe and recurrent disability; (iii) that produces functional limitations in the individual's major life activities which are documented in the individual's medical record; and (iv) that the individual requires individualized training in order to achieve or maintain independent living in the community.
- _____ The individual shall require individualized training in acquiring basic living skills such as symptom management; adherence to psychiatric and medication treatment plans; development and appropriate use of social skills and personal support system; personal hygiene; food preparation; or money management.
- _____ The individual shall have a prior history of any of the following: psychiatric hospitalization; residential crisis stabilization; Intensive Community Treatment (ICT) or Program of Assertive Community Treatment (PACT) services; placement in a psychiatric residential treatment facility (RTC-Level C); or TDO evaluation as a result of decompensation related to serious mental illness. This criterion shall be met in order to be initially admitted to services, and not for subsequent authorizations of service.
- _____ The individual shall have had a prescription for anti-psychotic, mood stabilizing, or anti-depressant medications within the 12 months prior to the assessment date. If a physician or other practitioner who is authorized by his license to prescribe medications indicates that anti-psychotic, mood stabilizing, or anti-depressant medications are medically contraindicated for the individual, the provider shall obtain medical records signed by the physician or other licensed prescriber detailing the contraindication. This documentation shall be maintained in the individual's mental health skill-building services record, and the provider shall document and describe how the individual will be able to actively participate in and benefit from services without the assistance of medication. This criterion shall be met in order to initially admitted to services, and not for subsequent authorizations of service.

C. Therapeutic Day Treatment.

Therapeutic day treatment is appropriate for children and adolescents who meet one of the following:

- _____ Children and adolescents who require year-round treatment in order to sustain behavior or emotional gains.
- _____ Children and adolescents whose behavior and emotional problems are so severe they cannot be handled in self-contained or resource emotionally disturbed (ED) classrooms without:
 - (1) This programming during the school day; or
 - (2) This programming to supplement the school day or school year.
- _____ Children and adolescents who would otherwise be placed on homebound instruction because of severe emotional/behavioral problems that interfere with learning.
- _____ Children and adolescents who (i) have deficits in social skills, peer relations or dealing with authority; (ii) are hyperactive; (iii) have poor impulse control; (iv) are extremely depressed or marginally connected with reality.
- _____ Children in preschool enrichment and early intervention programs when the children's emotional/behavioral problems are so severe that they cannot function in these programs without additional services.

AND

- _____ Such services shall not duplicate those provided by the school.

AND

Individuals qualifying for this services shall demonstrate a clinical necessity for the service arising from a condition due to mental, behavioral, or emotional illness which results in significant functional impairments in major life activities. Individuals shall meet at least two of the following criteria on a continuing or intermittent basis:

- _____ Have difficulty in establishing or maintaining normal interpersonal relationships to such a degree that they are at risk of hospitalization, or out-of-home-placement because of conflicts with family or community.
- _____ Exhibit such inappropriate behavior that repeated interventions by the mental health, social services, or judicial system are necessary.
- _____ Exhibit difficulty in cognitive ability such that they are unable to recognize personal danger or recognize significantly inappropriate social behavior.

Clinical Review Section (to be completed by reviewing LMHP):

The following materials were reviewed by the licensed professional in consideration of the requested service(s):

___ CSA Individual Family Service Plan (IFSP)

___ Virginia Child and Adolescent Needs and Strengths Assessment (CANS)

___ FAPT Minutes

___ Case Manager/Family/Client Reports (please circle those that apply)

___ Other pertinent documentation (e.g., IEP, VEMAT, medical/psychiatric documentation).

Please list:

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LMHP Certification Statement: My signature certifies I have reviewed the abovementioned materials and determined the client meets the clinical necessity criteria for the recommended service(s).

Name of LMHP (Printed)

**Signature of LMHP
(including credentials)**

Date