Assertive Community Treatment (ACT) Outpatient Treatment Request (OTR) Form

AmeriHealth Caritas Louisiana

Date:	Member name:
☐ Initial request	# Units requested:
☐ Continued stay/Requesting additional units Last authorization #:	CPT: H0039 Modifiers:
Date member initially start receiving services: Units will be authorized at one unit per month.	Authorization start date: Authorization end date:

Member DOB:	Medicaid/Health plan #:
Legal guardian if not self:	Member phone #:
Member address:	
City, state:	ZIP:

Requesting provider:	Servicing provider: ☐ same as requesting
NPI#:	NPI#:
TIN#:	TIN#:
LMHP/MD name:	LMHP/MD name:
Contact name:	Contact name:
Contact phone:	Contact phone:
Contact fax:	Contact fax:
Contact email:	Contact email:

DSM diagnosis code:
ICD-10 code:
Level of functional impairment: ☐ No impairment ☐ Mild ☐ Moderate ☐ Severe
Risk of harm to self or others: ☐ No risk ☐ Mild ☐ Moderate ☐ Severe
Progress towards goals: ☐ N/A (initial request) ☐ Making progress towards goals ☐ Lack of adherence and/or progress

PLEASE SUBMIT THIS FORM WITH THE FOLLOWING ITEMS:

For initial authorization	
☐	An initial assessment that includes psychiatric history, mental status exam, diagnosis, and information needed to determine medical necessity and, if the member meets eligibility criteria, to receive ACT services
☐	LOCUS scoresheet signed by an LMHP, on a form that includes the rating in each dimension, the criteria to support the rating, independent criteria, the composite score, the level of care, a section to document notes, a signature line with credentials, and a rating date
☐	Initial treatment plan (including goals with focus of treatment and transition/discharge plan) with signatures of member, team leader, and prescriber
☐	Member choice/Freedom of choice form

For continuing stay authorization:	
☐	Comprehensive person-centered needs assessment updated every six months • The sections of the person-centered needs assessment shall be completed by ACT team members with subject matter expertise as indicated by their role within the program. • The entire assessment shall be reviewed and signed off on by the LMHP.
☐	LOCUS scoresheet signed by an LMHP, on a form that includes the rating in each dimension, the criteria to support the rating, independent criteria, the composite score, the level of care, a section to document notes, a signature line with credentials, and a rating date.
☐	Treatment plan (including goals with focus of treatment and transition/discharge plan) updated every three months with signatures of member, team leader, and prescriber.
☐	ACT Transition Assessment Scale updated every six months
☐	Career profile/Vocational assessment updated every six months
☐	Progress summary completed within the past 30 days of the continuing stay authorization request. A progress summary shall include the following: • Document the time period summarized. • Indicate who was contacted, where contact occurred and what activity occurred. • Record activities and actions taken, by whom, and progress made. • Indicate how the member is progressing toward the personal outcomes in the treatment plan, as applicable. • Document delivery of each service identified on the treatment plan, as applicable. • Document any deviation from the treatment plan. • Record any changes in the member's medical condition, behavior, or home situation that may indicate a need for a reassessment and treatment plan change, as applicable. • Be legible (including signature) and include the functional title of the person making the entry and date.

By my signature below, I hereby attest that all of the information above is true and accurate to the best of my knowledge.	
Printed LMHP/Provider name and credentials:	
Signature of provider/clinician:	
Submitted by:	Date: