FIDELIS CARE®

Behavioral Health Service Request Form

Residential Treatment Request Form

Please Submit to the Dedicated Fax Line Below

Medicaid
Call for Pre-Certification of Admissions: 888-453-2534
New Jersey Medicaid Fax: 855-703-8082

Place of Service	☐ **55- Residential Substance Abuse Treatment Facility** ☐ **56- Psychiatric Residential Treatment Center** ☐ **14- Group Home**

MEMBER INFORMATION					
Last Name		**First Name, Middle Initial**		**Date of Birth**	
Phone Number		**ID Number**		**Gender**	☐ **Male** ☐ **Female**
Third Party Insurance	☐ **Yes** ☐ **No**	If **Yes**, please attach a copy of the insurance card. If the card is not available, provide the name of the insurer, policy type, and number.		**Languages Spoken**	

TREATING PROVIDER/PRACTITIONER INFORMATION					
Last Name		**First Name**		**NPI Number**	
ID Number		**Participating**	☐ **Yes** ☐ **No**	**Discipline/ Specialty**	
Street Address		**City, State**		**Zip**	
Phone Number		**Fax Number**		**Office Contact**	

FACILITY/AGENCY INFORMATION					
Name		**Facility ID**		**NPI Number**	
Street Address		**City, State**		**Zip**	
Phone Number		**Fax Number**		**Office Contact**	

Service Type Requested		**List REV/ HCPCS Code(s)**		
Residential: ☐ **Mental Health** ☐ **Substance Abuse**				
Effective Date Requested:	**Projected Length of Stay :**	**Original Admission Date(if different from Effective Date) :**	**Transition of Care** ☐ **Yes** ☐ **No**	**Continuity of Care** ☐ **Yes** ☐ **No**

DIAGNOSIS – Code and Description	
Primary Diagnosis	
Secondary Diagnosis	
Medical Diagnosis	
Are services court ordered? ☐ **Yes** ☐ **No** ***If yes please submit a copy of the court order and all supporting documentation***	

INITIAL REVIEW REQUESTS **(For Continued Stay Review – go to next page)**
Presenting problem to be addressed by treatment plan:

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Date problem began		**Duration**		**Is member under the care of a psychiatrist**	☐ Yes ☐ No
Is member currently inpatient	☐Yes ☐ No	**If yes, what facility is member admitted and what is the current length of stay?**			

Does the member have any chronic illnesses that require staff supervision?
If yes, indicate the illness, the severity and how staff time and resources are utilized.

Has the member experienced any acute illnesses, medical complications or medical hospitalizations during the last three months?

Does the member have a current Substance Use Disorder? ☐ **Yes** ☐ **No**

If yes, please list substance(s) used :

Substances Used in the Past Year:	Frequency of Use :	Amount Used:	Last Use :

Has the member exhausted all lower levels of care?	☐ **Yes** ☐ **No**

Please explain why the member cannot be managed safely in a less intensive level of care :

CURRENT/PREVIOUS TREATMENT

Is member currently receiving Outpatient services?
☐ **Yes** ☐ **No**

If yes :

Name of Provider / Facility :	Dates :	Compliant :
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Any Previous Inpatient, Residential/Rehab, PHP, or IOP treatment? ☐ **Yes** ☐ **No**

Level of Care :	Name or Provider / Facility :	Dates:	Compliant :
Inpatient :			☐ Yes ☐ No
Residential :			☐ Yes ☐ No
Partial Hospitalization :			☐ Yes ☐ No
IOP/PHP			☐ Yes ☐ No
Intensive Community Based Treatment :			☐ Yes ☐ No

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If treatment / placement was not successful, please explain:	
Has the member exhausted all lower levels of care?	☐ Yes ☐ No
Please explain why the member cannot be managed safely in a less intensive level of care :	

MENTAL STATUS EXAM AND SYMPTOMS

Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; N/A = not assessed
Check the current level of impairment for each category and provide a brief description :

Symptom:	Scale:	Description:	Symptom:	Scale:	Description:
Depressed Mood	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Substance Abuse / Dependence	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Self-Mutilation	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Substance Use Withdrawal	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Impaired Attention/Concentration	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Cravings	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Impulsivity/Dangerous Behaviors	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Cruelty to animals	☐ 0 ☐ 1 ☐ 2 ☐ 3 ■ N/A	
Work/School/ADL Problems	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Memory Impairment	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Delusions	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Impaired Judgement	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Eating Disorders	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Lack of Insight	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Fire Setting	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Generalized Anxiety	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Obsession/Compulsion	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Sexually Inappropriate/Aggressive	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Illegal Activities	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A				

Suicidal/Homicidal ☐ Ideation ☐ Plan **Provide details including previous attempts and dates :**	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A
Hallucinations: ☐ Auditory ☐ Visual ☐ Command **Provide details including previous examples and dates :**	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A

SUPPORT SYSTEMS & PERFORMANCE

Relationships/Supports (issues / concerns; Is support available / Is support substance free?)
Please provide details:

Role performance school/work issues/concerns:
Please provide details:

Current living situation? ☐ homeless ☐ independent ☐ family ☐ foster home ☐ incarcerated ☐ other:

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CURRENT MEDICATIONS (Psychotropic and Medical)

Medication:	Dosage :	Frequency :	Compliant :
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
Are there any medication contraindications? If yes, please describe :			

Discharge Plan upon Admission:

ATTACHMENTS

☐ Current Treatment Plan	☐ Incident Report(s)	☐ Psychological Report	☐ Psychiatric Report	☐ Other:

CONTINUED STAY REVIEWS

For continued stay, provide a narrative of the current symptoms/behaviors that have occurred within the last week that support the need for residential care. Summarize the progress or lack of progress and justification for continued stay. If there is no documented progress, explain how this is being addressed.

Continued symptoms/behaviors:

Scale: 0 = none; 1 = mild; 2 = moderate; 3 = severe; N/A = not assessed
Circle the impairment level for each category and provide a brief description

Symptom:	Scale:	Description:	Symptom:	Scale:	Description:
Functioning	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Ability to follow instructions	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	
Complete assignments	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A		Perform ADLs	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ N/A	

Types of services offered	Total number of sessions attended	Total number of sessions missed	Member cooperative with treatment	Please provide an explanation of any "NO" responses
Individual Counseling			☐ Yes ☐ No	
Group Counseling			☐ Yes ☐ No	
Psychiatric interventions			☐ Yes ☐ No	
Family Counseling			☐ Yes ☐ No	
Substance Abuse Counseling			☐ Yes ☐ No	
Sexual Reactive Treatment			☐ Yes ☐ No	
Sexual Offender Treatment			☐ Yes ☐ No	
Other services			☐ Yes ☐ No	

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Has the member's behavior necessitated a significant change in treatment, medication, or supervision? ☐ Yes ☐ No
If yes, please specify the changes (use a separate sheet if necessary)

Current Medications (Psychotropic and Medical)

Medication:	Dosage :	Frequency :	Compliant :
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
Are there any medication contraindications? If yes, please describe :			

Method of Intervention	Frequency	Has the use of these methods become more frequent? If so, please explain
Use of Time-out		
Physical management/Restraint (does not include escorts or assists)		
Calls for outside assistance (law enforcement, non-agency staff, etc.)		
Other		
Updates to Discharge Plan:		Expected discharge date:

ATTACHMENTS

☐ Current Treatment Plan	☐ Incident Report(s)	☐ Psychological Report	☐ Psychiatric Report	☐ Other: