

CareOregon Level of Care Authorization Form



Adult Mental Health Services Initial Treatment Registration Form

CareOregon®

Member Information

Member name: _____ OHP ID: _____

Date of birth: _____

Provider: _____ Location: _____

Service period start date: _____ End date: _____

Admission LOC requested

- | | | | |
|---|---------------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> A ADULT MRDD/IDD | <input type="checkbox"/> A ADULT | <input type="checkbox"/> B ADULT | <input type="checkbox"/> B ADULT SPMI |
| <input type="checkbox"/> C ADULT | <input type="checkbox"/> C ADULT SPMI | <input type="checkbox"/> D ADULT TAY | <input type="checkbox"/> D ADULT ICM |

Admission Clinical Criteria *(please check all that apply)*

Level A ADULT MRDD/IDD

- Covered diagnosis on the prioritized list
- AND one of the following:**
 - Need for care coordination with DD services and ongoing medication management
 - Need for medication management for a medication regime that is more complicated than generally provided in primary care

Level A ADULT

- BOTH of the following:**
 - Covered diagnosis on the prioritized list
 - Episodic depression, anxiety or other mental health conditions with no recent hospitalizations and limited crisis episodes within the past year
- AND at least one of the following:**
 - Mild functional impairment
 - A presentation that is elevated from baseline

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<p>Level B ADULT</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Covered diagnosis on the prioritized list <p>AND at least one of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Moderate risk of harm to self or others <input type="checkbox"/> Moderate functional impairment in at least one area such as such as housing, financial, social, occupational, health and activities of daily living <input type="checkbox"/> Individual has a marginalized identity that creates barriers to receiving appropriate services, and/or individual's level of English language skill and/or cultural navigation barriers is not sufficient to achieve symptom or functional improvement without additional supports
<p>Level B ADULT SPMI</p>	<p>ALL the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Covered diagnosis on the prioritized list <input type="checkbox"/> No hospitalizations or major crisis episodes within the past year <input type="checkbox"/> No risk of harm to self or others or risk of harm to self or others that is consistent with baseline presentation <p>AND at least two of the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Symptoms related to the mental illness result in a moderate functional impairment and are fairly well controlled <input type="checkbox"/> Individual able to navigate system with minimal to moderate support OR has supports (such as family or AFH) in place to meet client's needs <input type="checkbox"/> Low to moderate psychosocial stress (housing and benefits are generally stable) <input type="checkbox"/> Individual is generally functioning at baseline <input type="checkbox"/> Individual has extended periods of abstinence when a co-occurring disorder exists, and risk factors are minimal <input type="checkbox"/> Individual has a marginalized identity that creates barriers to receiving appropriate services, and/or individual's level of English language skill and/or cultural navigation barriers is not sufficient to achieve symptom or functional improvement without additional supports

**Level C
ADULT**

- Covered diagnosis on the prioritized list
- AND at least two of the following must be met:**
- Risk of harm to self or others or at risk of harm to self or others that is escalated from baseline
- Moderate functional impairment in at least two areas (such as housing, financial, social, occupational, health, activities of daily living)
- At least one hospitalization within the last six months
- Multiple system involvement requiring coordination and case management
- Risk of loss of current living situation, in an unsafe living situation, or currently experiencing homelessness due to symptoms of mental illness
- Significant current substance abuse for which integrated treatment is necessary
- Significant PTSD or depression symptoms as a result of torture, ongoing systemic oppression, trauma or multiple losses
- Extended or repeated crisis episode(s) requiring increased services
- Individual has a marginalized identity that creates barriers to receiving appropriate services, and/or individual's level of English language skill and/or cultural navigation barriers is not sufficient to achieve symptom or functional improvement without additional supports
- Diagnosis and/or age-related functional deficits and/or complex medical issues requiring substantial coordination

**Level C
ADULT
SPMI**

TWO of the following:

- Covered diagnosis on the prioritized list
- Significant assistance required to meet basic needs such as housing and food
- Significant PTSD or depression symptoms as a result of torture, ongoing systemic oppression, trauma or multiple losses

AND at least two of the following:

- At least one hospitalization within the past year
- Symptoms related to the mental illness result in a moderate to significant functional impairment and are only partially controlled
- Risk of harm to self or others or risk of harm to self or others that is escalated from baseline
- Multiple system involvement requiring substantial coordination
- Extended or repeated crisis episode(s) requiring increased services
- Significant current substance abuse for which treatment is necessary
- Risk of loss of current living situation, in an unsafe living situation, or currently experiencing homelessness due to symptoms of mental illness
- Individual has a marginalized identity that creates barriers to receiving appropriate services, and/or individual's level of English language skill and/or cultural navigation barriers is not sufficient to achieve symptom or functional improvement without additional supports
- Diagnosis and/or age-related functional deficits and/or complex medical issues requiring substantial coordination

**Level D
ADULT ICM**

Covered diagnosis on the prioritized list

AND at least two of the following:

Two or more inpatient admissions in the past year

Recent discharge from the state hospital (within the past year)

Civil commitment or discharge from the state hospital (within the past year)

Residing in an inpatient bed or supervised community residence and clinically assessed to be able to live in a more independent living situation if intensive services are provided

Severe deficits in skills needed for community living as well as a high degree of impairment due to symptoms of mental illness

Significant PTSD or depression symptoms as a result of torture, ongoing systemic oppression, trauma or multiple losses

OR at least three of the following:

Intractable, severe major symptoms

Significant cultural and linguistic barriers exist

Significant criminal justice involvement

Requires residential placement if intensive services are not available

Not engaged in services but deemed at high risk of harm related to their mental illness

Severe deficits in skills needed for community living as well as a high degree of impairment due to symptoms of mental illness

Co-occurring addiction diagnosis

Risk of loss of current living situation, in an unsafe living situation, or currently experiencing homelessness due to symptoms of mental illness

**Level D
ADULT TAY**

Covered diagnosis on the prioritized list

AND at least one of the following:

- Two or more inpatient admissions in the past year
- Recent discharge from the youth's Secure Inpatient adolescent program or long-term psychiatric residential treatment services
- Residing in an inpatient bed or supervised community residence and clinically assessed to be able to live in a more independent living situation if intensive services are provided
- Severe deficits in skills needed for community living as well as a high degree of impairment due to symptoms of mental illness

OR at least three of the following:

- Intractable, severe major symptoms
- Significant cultural and language barriers exist
- Significant criminal justice involvement
- Requires residential placement if intensive services are not available
- Not engaged in services but deemed at high risk of harm related to their mental illness
- Severe deficits in skills needed for community living as well as a high degree of impairment due to symptoms of mental illness
- Co-occurring addiction diagnosis
- Risk of loss of current living situation, in an unsafe living situation, or currently experiencing homelessness due to symptoms of mental illness
- Significant PTSD or depression symptoms as a result of torture, ongoing systemic oppression, trauma or multiple losses

Clinically Assessed Level of Care

<input type="checkbox"/> A ADULT MRDD/IDD	<input type="checkbox"/> B ADULT
<input type="checkbox"/> A ADULT	<input type="checkbox"/> B ADULT SPMI
<input type="checkbox"/> C ADULT OUTPATIENT	<input type="checkbox"/> D ADULT ICM
<input type="checkbox"/> C ADULT SPMI	<input type="checkbox"/> D ADULT TAY

Level of Care Assigned

(Optional: Only needed if LOC assigned is different from clinically assessed LOC)

<input type="checkbox"/> A MRDD/IDD	<input type="checkbox"/> B ADULT
<input type="checkbox"/> A ADULT	<input type="checkbox"/> B ADULT SPMI
<input type="checkbox"/> C ADULT	<input type="checkbox"/> D ADULT ICM
<input type="checkbox"/> C ADULT SPMI	<input type="checkbox"/> D ADULT TAY

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 retroactive 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.