CT BHP RE-REGISTRATION/CONCURRENT REVIEW FORM – REGISTERED SERVICES
ALL FIELDS WITH * ARE REQUIRED

Provider EDS/CMAP ID # (Medicaid 9-digit ID) ______________________________

Name of clinician who filled out this form______________________________**Credentials/Title** ______________

Facility/Provider Name______________________________**Telephone Number**______________

Facility/Provider Service Location ______________________________

Member Name ______________________________

Medicaid/Consumer ID#____________________**DOB**:______________***AND/OR*** **SSN**: ____________

LEVEL OF CARE: ☐ **Intensive Outpatient** ☐ **EDT** ☐ **Outpatient** ☐ **Methadone Maintenance** ☐ **Ambulatory Detoxification**
☐ **Home Based Services** ☐ **IICAPS** ☐ **MDFT** ☐ **MST** ☐ **FFT**

***Contact name** ____________________ ***Contact number**______________**Ext:**__________

If APPLICABLE, PLEASE INDICATE IF ANY OF THE FOLLOWING NEED TO BE UPDATED

1) **Behavioral Diagnoses (*Primary is required)***

***Diagnosis Code:** ____________ ***Description**______________________________

***Diagnostic Category:** ______________________________

Diagnosis Code: ____________ **Description**______________________________

Diagnostic Category: ______________________________

2) **Primary Medical Diagnoses *(Primary is required or indicate "None" or "Unknown")***

***Diagnosis Code:** ____________ ***Description**______________________________

***Diagnostic Category:** ______________________________

Diagnosis Code: ____________ **Description**______________________________

Diagnostic Category: ______________________________

3) ***Social Elements Impacting Diagnoses (Required - Check all that apply)**

☐ None ☐ Educational problems ☐ Financial problems ☐ Housing problems (Not Homelessness)
☐ Occupational problems ☐ Other psychosocial and environmental problems ______________________
☐ Problems with access to health care services ☐ Homelessness
☐ Problems related to interaction with legal system / crime ☐ Problems with primary support group
☐ Problems related to social environment ☐ Unknown

4) **Functional Assessment *(Optional)***

☐ CDC- HRQOL ☐ CGAS ☐ FAST ☐ GAF ☐ OMFAQ ☐ SF12 ☐ SF36 ☐ WHO DAS

☐ OTHER ______________________ ASSESSMENT SCORE__________

Facility/Provider Name____Member Name or ID# ______________________________

5) Current Risks

Key: **0 = None** **1 = Mild or Mildly Incapacitating** **2 = Moderate or Moderately Incapacitating** **3 = Severe or Severely Incapacitating** **N/A = Not Assessed**

a) *Members Risk to Self 0 ☐ 1 ☐ 2 ☐ 3 ☐

b) *Members Risk to Others 0 ☐ 1 ☐ 2 ☐ 3 ☐

6) Current Impairments

***Mood Disturbances (Depression or Mania)**
☐0 ☐1 ☐2 ☐3 ☐N/A

***Anxiety**
*
☐0 ☐1 ☐2 ☐3 ☐N/A

***Psychosis / Hallucinations / Delusions**
☐0 ☐1 ☐2 ☐3 ☐N/A

***Thinking/Cognitive/Memory/Concentration Problems**
☐0 ☐1 ☐2 ☐3 ☐N/A

***Impulsive/Reckless/Aggressive Behavior**
☐0 ☐1 ☐2 ☐3 ☐N/A

***Activities of Daily Living Problems**
☐0 ☐1 ☐2 ☐3 ☐N/A

***Impairments Related to Loss/Trauma**
☐0 ☐1 ☐2 ☐3 ☐N/A

***Weight Changes Associated with Behavioral Diagnosis**
☐0 ☐1 ☐2 ☐3 ☐N/A

For 2 or 3 rating:
Weight ☐Gain ☐Loss ☐N/A

Past 3 mos_______Lbs ☐N/A
Current Wt________Lbs ☐N/A
Height_______Ft_______In ☐N/A

***Medical / Physical Conditions**
☐0 ☐1 ☐2 ☐3 ☐N/A

***Substance Abuse / Dependence**
☐0 ☐1 ☐2 ☐3 ☐N/A
For 2 or 3 rating: Check all that apply
☐ Alcohol ☐ Illegal Drugs ☐ Prescription Drugs

***Job/School/Performance Problems**
☐0 ☐1 ☐2 ☐3 ☐N/A

***Social Functioning/Relationships/Marital/Family Problems**
☐0 ☐1 ☐2 ☐3 ☐N/A

***Legal**
☐0 ☐1 ☐2 ☐3 ☐N/A
For 1, 2 or 3 rating: Check all that apply
☐Juv Justice ☐Probation ☐Parole ☐Other Court

7) Does Member have co-occurring mental health and substance abuse conditions? ☐Yes ☐No ☐Not Assessed

8) Indicate degree of progress from previous registration: ☐None ☐Minimal ☐Moderate ☐High

9) Treatment Modalities to be used with this request:

a. **Family:** ☐Yes ☐No **If yes,** ☐Weekly ☐Monthly ☐Quarterly ☐Other
Individual: ☐Yes ☐No **If yes,** ☐Weekly ☐Monthly ☐Quarterly ☐Other
Group: ☐Yes ☐No **If yes,** ☐Weekly ☐Monthly ☐Quarterly ☐Other
Med Mgmt: ☐Yes ☐No **If yes,** ☐Weekly ☐Monthly ☐Quarterly ☐Other

10) Federal Reporting Requirements (*To be completed for members ages 0-18, not including the 18th birthday*):

a. **SED (Seriously/Severely Emotionally Disturbed):** ☐Yes ☐No ☐Unknown

b. **Co-occurring Disorder:** ☐Yes ☐No ☐Unknown

c. **Living Situation:**

☐Crisis Stabilization Residential ☐Foster Care (Standard) ☐Foster Care (Therapeutic or Professional) ☐Group Home ☐Homeless ☐Independent Living w/ Supports ☐Jail/Correctional Facility ☐Private Residence ☐Psychiatric Residential Treatment Facility ☐Residential Treatment Center ☐Safe Home ☐Shelter

d. **Within the last 12 months has the child/youth been arrested?** ☐Yes ☐No ☐Unknown

e. **Within the last 12 months has the child/youth been suspended / expelled?** ☐Yes ☐No ☐Unknown

11) **Continuation of Federal Reporting Requirements**

During 90 days prior to this request for re-authorization has:

- **a. Member been enrolled in school?** ☐Yes ☐No, Graduated ☐No, Expelled ☐No, Dropped Out
- **b. If member is enrolled in school, has member been suspended from school?** ☐Yes ☐No
- **c. If member is enrolled in school, does member have unexcused attendance problems?** ☐Yes ☐No
- **d. Member's behavior resulted in new legal problems?** ☐Yes ☐No ☐Unknown
- **e. Any new legal charges brought against member?** ☐Yes ☐No ☐Unknown
- **f. Family member been involved in any peer support activities?** ☐Yes ☐No ☐Unknown
- **g. Member been actively involved in any organized recreational activities?** ☐Yes ☐No ☐Unknown
- **h. Does the child's care plan include a goal of involvement in organized recreational activities?** ☐Yes ☐No ☐Unknown
- **i. During the past 3 months have you communicated with PCP or other medical provider?** ☐Yes ☐No
- **j. During the past 3 months have you communicated with any of the following regarding care and treatment of member:**
  - **School:** ☐Yes ☐No ☐Child not enrolled in school
  - **DCF:** ☐Yes ☐No ☐Child not DCF involved
  - **Probation / Parole:** ☐Yes ☐No ☐Child not involved with Probation / Parole

12) **Describe additional details for this request that will pend for review:**

- **a. Requested number of days or units: ___________**
- **b. Start Auth Date: _______________**
- **c. End Auth Date: _______________**
- *d. **Rationale for continued request** (maximum of 1000 characters)**:**

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