Banner
University Health Plans

Concurrent Review Request for Adult Behavioral Health Residential Facility Treatment (BHRF)

E-mailed to UHPBHUM_OOH_CCR@Bannerhealth.com

Do not leave lines blank. Please mark as not applicable if an item does not apply. Please complete this form electronically.

This application is for short-term treatment at a residential facility. Please review the additional information on this page prior to completing the application.

Date of Request:

Facility Name:

Person Completing the request:

Member Name: AHCCCS ID:

Initial Admission Date:

Date of Admit:

Current Last Covered Day:

Guidelines for Continued Stay:

Continued stay must be assessed by the BHRF staff and the ART during the service plan review and update. Progress towards the treatment goals and continued display of risk and functional impairment must also be addressed. Treatment intervention, frequency, crisis/safety planning and targeted discharge must be adjusted accordingly to support the need for continued stay.

The following criteria will be considered when determining continued stay:

1. The member continues to demonstrate significant risk of harm and/or functional impairment as a result of a behavioral health condition consistent with the criteria for admission.
2. Providers and supports are not available to meet current behavioral and physical health needs at a less restrictive lower level of care.
3. Member is making progress towards identified goals or if there is lack of progress the facility and complete care plan are revised resulting in the expectation of improvement.
4. The member is demonstrating marked improvement toward the one or more identified area of significant risk of harm that was identified during the admission/evaluation period.

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Date Form Completed:

Background Information:

Member Name:

Gender:

Date of Birth: **Age:** **AHCCCS ID:**

Diagnoses:

Facility Name:

Facility Address:

Person Requesting Concurrent Review Request:

Name:

Phone Number:

Email Address:

Was member absent for more than 24 hours since last review? (Yes or No) **If so, when and why?**

What is member's source of income?

Does the member have a Rep Payee? (Yes or No) **If YES, provide contact information.**

What is the amount of member's monthly income?

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Current Treatment and Progress

Date of last ART meeting? (please attach last art meeting note)

ART must include the OP provider that will follow up w/member after discharge for follow-up.

When is the next ART meeting? If an ART meeting was NOT held please provide an explanation.

Date of last psychiatric appointment?

If applicable - Did the member attend the 7-day post-hospitalization appointment?

Date of next psychiatric appointment?

Name, credentials, and contact information of person providing 1:1 therapy

Dates of 1:1 therapy since last update:

Current medications:

Psychotropic Medications	Medical Medications

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Date of any recent changes? Are there any side effects to the medications?

Any issue accessing medications. If there was how was that resolved? Any medications change?

What are the current SMART goals? (Specific, Measurable, Attainable, Reasonable, Time-Bound)

	Need	Goal	Measurement of Progress
1.			
2.			
3.			
4.			

What goals has member successfully completed?

Please provide specific examples of member's improvement on goals that have not been completed (Goals 1-4).

Does a Significant risk of harm still exist? Yes/ no check box. If so, what are the specific risks?

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What clinical interventions are being utilized to address the identified risks?

What impairment/deficits in functioning continue to exist? Please provide examples.

What groups have they been attending, when, and where?

Group Name	Frequency	When	Where

What goals/treatment are being provided in BHRF that can't be provided in a lower level of care?

Risk assessment: any aggression, deterioration in their mental health status and if so, what happened, when and why? What actions were taken by the facility and outpatient clinic?

If member is refusing to participate in treatment, i.e. therapy, groups how is the facility addressing this and attempting to engage member?

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Substance Use:

Any positive drug screening since the last review?

***Discharge Information**

What will member's mailing address and phone number be when they leave the facility?

Outpatient clinic contact information:

Person Involved in ART meetings:

Staff Title:

Phone Number:

Email Address:

What are the member's discharge plans?

Plan A:	
Plan B:	
Plan C:	

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What are the specific barriers to transitioning member to a less restrictive level of care?

How are the barriers being addressed? Details for each barrier.

Was an SMI evaluation completed? If so, when, and results?

What natural supports (friends, family, community services) does member have?

What date was PYX offered to member? Did member download Pyx? Yes or No.
If Pyx not downloaded, why not?

If this member will be stepping down within the next 2 weeks, what is the date, time, and provider for all step down appointments:

Appointment Type	Date and Time	Contact Info
BHMP		
PCP		
Therapy		
Case Management		
ART Meeting		

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If there is any additional information related to this member's need for ongoing stay in an out of home BHRF please note in the space below.

Please email completed review and ART note to: UHPBHUM_OOH_CCR@Bannerhealth.com