RIVERSIDE UNIVERSITY HEALTH SYSTEM – BEHAVIORAL HEALTH

TREATMENT EXTENSION/CHANGE REQUEST

☐ *Extension TAR* ☐ *Change TAR*

Type of Plan: ☐ Medi-Cal (CARES) ☐ Extension Assessment Date: _____

Provider: _____ Provider #: 33 _____

Provider Phone #: _____ Provide Fax #: _____

Consumer Name: _____
First Last

If child, caregiver/parent name: _____

Consumer DOB: _____ Consumer Medi-Cal #: _____

Consumer SS#: _____ Gender: ☐ M ☐ F

Consumer's Primary Language: _____ Consumer's Ethnicity: _____

Interpretation Services Offered: ☐ Yes ☐ No

Type of Living Situation: ☐ Group Home ☐ Bio Parent(s) ☐ Legal Guardianship ☐ Adopted Parent(s) ☐ Foster Home
☐ FFA (Private Foster Home) ☐ Relative Placement (Minors) ☐ Shelter Home ☐ Board & Care
☐ IMD ☐ SNF ☐ Independent Living ☐ Other _____

Name of Residential Facility (if Applicable): _____

Date of Placement: _____

Consumer's Current Address: _____

Consumer's Phone Number(s): _____

Diagnosis: (Treatment, goals, objectives, etc must be consistent with the current diagnosis). Put a "P" next to the Primary Diagnosis.

ICD-10 Code: _____ _____
_____ _____
_____ _____

DSM: Axis I: _____ _____
_____ _____
_____ _____

Axis II: _____ _____

General Medical Conditions:

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Consumer Name: _____ Social Security #: _____

Current Medication(s) and Dosage(s): _____

_____

Prescribed By: _____

Current Harm Assessment:				
Suicide Ideation:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Suicide Intent:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Homicidal Ideation:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Homicidal Intent:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Self-Injurious Behavior:	☐ None	☐ Mild	☐ Moderate	☐ Severe

If any at present, describe type and frequency of ideation, plan, and means: _____

_____

MEDICAL NECESSITY: Describe specifically how symptoms impair a specific area of functioning; i.e.: work, school, health/safety, social. (For children there must be a reasonable probability/risk of significant deterioration in an important area of life functioning). **USE CURRENT DSM CRITERIA WHEN POSSIBLE**:

_____

Dysfunction Rating: ☐ None ☐ Mild ☐ Moderate ☐ Severe

Recommendations (Reasons for continued treatment/reason for change/expected duration of treatment):

_____

_____

PROPOSED TREATMENT: ** For providers requesting authorization through CARES only.

Refer for Psychiatric Services: ☐ Yes ☐ No If yes, need to complete a "Provider Referral Request Form"
Refer for Therapy: ☐ Yes ☐ No

Psychiatric Evaluation/Medication Management: _____minute session(s) per ☐month / ☐quarter for _____ ☐weeks / ☐months
Individual Therapy: _____ session(s) per ☐week / ☐month / ☐quarter for _____ ☐weeks / ☐months (☐15 / ☐30 / ☐60 / ☐90 mins)
Group Psychotherapy: _____ session(s) per ☐week / ☐month _____ ☐weeks / ☐months
Family Therapy: _____ session(s) per ☐week / ☐month / ☐quarter for _____ ☐weeks / ☐months (☐30 / ☐60 minutes)
Collateral: _____ session(s) per ☐week / ☐month / ☐quarter for _____ ☐weeks / ☐months (☐30 / ☐60 minutes)
With: _____ Purpose: _____

Outpatient Consultation with: _____

Purpose: _____

Date treatment started: _____ Total # of sessions provider has completed with this consumer: _____

Progress on Goals: Describe the consumer's progress in meeting the previous goals (as stated on last Auth Request):

Goal (1):

_____

Goal (2):

_____

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New/Continuing Goals:

GOALS: Must be related to the specific impairment(s) listed above. Must be measurable/observable, and must include current frequency of the behavior, and the desired frequency.

Behavior Outcome/Goal #1: _____

_____

Target Date to Meet Goal #1: _____

Provider Intervention (Be Specific): _____

_____

Consumer Will (Be Specific): _____

_____

Behavior Outcome/Goal #2: _____

_____

Target Date to Meet Goal #2: _____

Provider Intervention (Be Specific): _____

_____

Consumer Will (Be Specific): _____

_____

_____ Provider's Signature and License	_____ Date
_____ Provider's Printed Name and Discipline	_____ Date
_____ Clinical Supervisor's Signature and License	_____ Date
_____ Consumer's Signature	_____ Date
_____ Parent/Guardian's Signature	_____ Date

Consumer offered a copy of Care Plan? ☐ Yes ☐ No ***Consumer received copy of Care Plan?*** ☐ Yes ☐ No _____ Date

Send Form to Appropriate Unit:
Community Access, Referral, Evaluation, & Support (CARES) – P. O. Box 7549, Riverside, CA 92513, Fax: (951) 358-5352