

UM Adult Checklist

Medicaid and Non-Innovations State Funded

Member: _____ Date Checklist
Initially Completed: _____

Assessments/Attachments

Done	Not Done	N/A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	For IPRS services, the member is eligible based on benefit plan, sliding scale criteria, and the service is available in the catchment the member resides
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CALOCUS/LOCUS completed and supports level of care or explanation listed
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ASAM Completed (to include narrative supporting level of care)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychological/Neuropsych (Required for TBI/MR)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Comprehensive Clinical Assessment (required for CST initial and all state funded services)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recovery Assessment Scale (RAS) completed for Peer Support
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Independent Living Skills assessment (for IPRS residential services)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	For family living or supervised living documentation of rent subsidy, household expenses, etc.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	SIS/Snap (IDD Non-Innovations State Funded)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fading plan (Safety and Supervision)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Provider Vacancy Announcement submitted (state funded residential)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MH/DD Waitlist Referral submitted (state funded residential)

Clinical Justification for Initial Services

Done	Not Done	N/A	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diagnosis completed and accurate, if any, deferred diagnosis explanation for this
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Clear clinical justification for services and frequency being requested
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Explanation as to why lower levels of care are not clinically appropriate— including previous services tried, when these were tried and outcomes
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation of prior hospitalizations (Dates and Reasons)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation of current behaviors and symptoms and frequency of these
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Completion of the SUD use section on the TAR when SUD diagnosis or use is reported
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Service request meets all service definition criteria
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Plan documents use of any best practices or treatment based on clinical guidelines
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Documentation of coordination with primary care physician or how this will occur and outlines and medical diagnosis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Current medication, frequency, dosage and compliance
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	The participants contributing to the PCP are identified. An attempt to include family and trusted others is addressed. Reasons for not including family and trusted others are documented
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Goals are relevant to consumer's diagnosis and services requested support those goals

- Goals support the need for the requested service
- Measurable step-down, transition plan included
- Service frequency listed is consistent throughout the PCP and associated TAR
- DSS, Court, Probation/Parole requirements are addressed in plan

Signature Requirements

- | Done | Not Done | N/A | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Signature page completed: |
| | | | <input type="checkbox"/> Legally Responsible Person <input type="checkbox"/> QP/LP <input type="checkbox"/> Consumer consent for SUD Services |
| | | | <input type="checkbox"/> Consumer/Guardian <input type="checkbox"/> Service Order |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dates for all signatures (license number on service order when applicable for LP, MD, PhD, etc.) |

Health and Safety

- | Done | Not Done | N/A | |
|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Services in the PCP reflect assessed risk factors |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Crisis Plan completed |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Crisis Plan identifies natural supports |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Crisis Plan addresses planning for withdrawal symptoms for members with SUD |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Relapse prevention plan, may include Wellness Recovery Action Plan (WRAP) |

For Reauthorization Requests

- | Done | Not Done | N/A | |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Documentation of progress or lack of progress towards goals |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | If lack of progress, documentation of changes to strategies and interventions |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Documentation of current behaviors and symptoms and frequency of these |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Date of last medication management visit and who prescribes (NP, psychiatrist, primary care, etc.) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Documentation of coordination with any family members, community stakeholders, other providers, etc. |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Evidence of coordination with primary care physician, including any medical conditions, and if seeing any specialty providers who these are |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | If there were any crisis episodes during the last authorization period, please describe and include reference to behaviors plans, safety plans, etc. that were developed |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Documentation of any changes in diagnosis, such as clarification of rule out or deferred diagnoses and any changes in medications |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | For CST past six months, a new complete comprehensive clinical assessment and a plan update including a service order |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | For ACTT, transition readiness scale (ATR) completed |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Date of last medication management visit and who prescribes (NP, psychiatrist, primary care, etc.) |

If a change to a service, including a frequency change, a new service is added, or goals are changed/modified, this should be done using a PCP update form. The *where am I now* section should provide the clinical details to support why the change is being made. If there is only a change in frequency or modified goals, this requires only the consumer/guardian and QP signature. If a new service is added, this requires a new service order.

Additional References

- A comprehensive list of (b)(3) services can be found [here](#). Accompanying service definitions can be found in Cardinal Innovations' [resource library](#) by searching (b)(3)
- Behavioral Health Clinical Coverage Policies [Here](#)
- State funded Clinical Coverage Policies [Here](#)
- For more information related to Unable to Process requests and why a Treatment Authorization Request may be marked as Unable to Process, please refer to the [Unable to Process Training](#).
- For information related to Person Centered Plan development:
 - o [Common PCP Errors](#)
 - o [PCP Development Hierarchy](#)
 - o [PCP Service & Frequency Tool](#)