| This form should be used to request outpatient treatment.<br><br>Revised 10.6.21 | COUNTY OF SAN DIEGO BEHAVIORAL HEALTH PLAN<br>**OUTPATIENT AUTHORIZATION REQUEST**<br><br>Please check: ☒ Initial Request ☐ Continuing Request<br>**PLEASE SUBMIT DEMOGRAPHIC FORM W/ INITIAL REQUESTS** | To request authorizations, fax or mail to:<br>Optum Public Sector<br>Fax: (866) 220-4495,<br>PO Box 601340<br>San Diego, CA 92160-1340<br>Phone: (800)798-2254, option 3 then 3 |
|---|---|---|

*CONFIDENTIAL* **Client Information** *CONFIDENTIAL*

| Client Last Name: First: Middle: | | Client Ethnicity: |
|---|---|---|
| Last Name, First Name Middle Name | Gender: ☒ M ☐ F ☐ O | Caucasian |

| Age: | DOB: | | |
|---|---|---|---|
| 47 | 05/18/1971 | Living Situation: ☒ Homeless ☐ Alone ☐ ILF ☐ B&C ☐ SNF<br>☐Other, with whom? Click here to enter text. | Justice System Involvement:<br>☐ N/A ☒ Yes: Possession of elicit substance 8/2021<br>If Yes,<br>explain: Arrested for possession. Pending court date. |

| Medi-Cal CIN #: | Highest Education Level: | Current Employment Status: |
|---|---|---|
| 00000000F | High school graduate | unemployed |
| Current Health Plan:<br>Care 1St | If Child, current IEP: ☐ Yes ☐ No<br>School District: | San Diego Regional Center Client: ☐ Yes ☒ No |

| Current Referral by Child Welfare Services: ☐Yes ☒No: | If Yes, PSW name and number: N/A |
|---|---|

If Hx of CWS, when and why? N/A

**DSM IV/ICD 10 Diagnosis and Other Clinical or Medical Considerations**

| Primary Diagnosis Description: Schizoaffective Disorder, Bipolar Type | ICD 10 Code:<br>F25.0 |
|---|---|

Other Diagnoses (Mental & Physical Health):
Other stimulant use, unspecified, Hypertension, Diabetes Type 2

**Presenting Mental Health Problem, Symptoms, Functional Impairment**

**Current Symptoms (please list w/ frequency and duration)**:
Client symptoms include: Daily auditory/visual hallucinations, grandiose delusions, mood swings that vacillate between episodes of mania (approx. 1x mo.) and major depression (6/7 days a week), sudden increase in energy, hyperverbal, feelings of worthlessness and sadness. Client reports daily, intermittent, passive SI with no plan or intent. Client has history of 2 suicide attempts-one at age 16 via cutting and one at age 33 via OD on medications and was recently hospitalized for psychotic behaviors in August 2021. Client is non-compliant with psychotropic medications and lost housing at last sober living as a result of aggression toward peers and relapse.

**How is the client significantly impaired in an important area of life functioning as a result of their symptoms or diagnosis? If client is a child, how is their development at risk of not progressing appropriately due to their symptoms or diagnosis:**
Symptoms impact client's ability to obtain employment, maintain relationships and housing. Client uses stimulants to self-medicate and does not effectively manage medical issues due to symptoms.

| Hx of Trauma and/or Abuse? ☒ Yes ☐ No | If Yes, explain:<br>Client reported childhood physical abuse from step-father and multiple assaults while homeless. |
|---|---|
| Substance Use: ☐ N/A ☐ HX ☒ Current | Drug(s) of choice: Client reports current methamphetamine use approx. 1x a week |

Describe current substance use impact on functioning:

Client lost his housing due to relapse at sober living and continues to use substances to manage mental health symptoms, though remains pre-contemplative regarding use and its impact.

| Current Risk Assessment: | | | | | | |
|---|---|---|---|---|---|---|
| | Suicidal - | ☐ N/A | ☒ Ideation | ☐ Plan | ☐ Intent | ☒ History of harming self |
| | Homicidal - | ☒ N/A | ☐ Ideation | ☐ Plan | ☐ Intent | ☐ History of harming others |

Client Strengths (i.e., motivated, employed, strong social supports): Client is resourceful and able to identify triggers to substance use. He reports being committed to treatment "this time around" due to recent loss of housing.

**Medications (Psychiatric, Medical, & OTC medications)**

Name of Medication w/ Dosage or N/A:

| | | |
|---|---|---|
| Depakote 500 mg TID | Click here to enter text. | Click here to enter text. |
| Abilify 20 mg daily | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. |

**Treatment**

Proposed Interventions (CBT, DBT, behavioral, strengths-based, groups, etc.): CBT, MI, and client-centered

If Group Therapy, # Participants: N/A Group Topic/Focus: N/A

Treatment plan with measurable/observable goals addressing diagnosis, functional impairments, and risk (include frequencies and duration of treatment goals and separate Individual and Group if facilitating both):
Goals include: maintain safety, secure housing, consistent medication management compliance, reduce substance use, develop safety plan, identify triggers to behaviors, implement coping skills in order to reduce risk for DTS/others, improve overall daily functioning and reduce Symptoms of depression, mania and psychosis.

-Reduce psychosis ( AH/VH) and manic symptoms by 50%
-Maintain safety 100% of the time through development of safety plan and identifying triggers
-Learn and implement 3 coping skills to reduce symptoms and prevent relapse
-Link to housing and substance use referrals
-Plan to later incorporate potential trauma work and symptoms management after obtaining basic needs.

Current treatment provided by others and/or Hx (i.e., Psychiatrist, PCP, NP, CM, TBS, Substance Use Tx, Groups, Peer Support):
No current psychiatrist. History of Crisis House and Case Management, though no current services. PCP through local FQHC.

How have you coordinated with these providers? If not, please explain: Plan to coordinate with PCP to increase medical care compliance and refer to psychiatrist.

Progress: ☒N/A (Initial Request) ☐ Near completion ☐ Improving ☐ Stabilizing ☐ Regressed due to new stressor ☐ Little/no progress

| | |
|---|---|
| Expected Length of Treatment: 6/12 months | If Initial Request, date of Assessment with you: 10/13/2021 |

Referrals made to other community supports and/or aftercare plans for client's recovery: Plan to provide linkage to psychiatrist and substance use referrals.

**Client Signature**

******I, (print name) Click here to* enter *text.participated in the development of this plan and received a copy.*

*Client Signature:* First Name Last Name *Date: 10/18/2021*

*(Signed Client Plan required in Client's Chart within 30 days of commencing treatment; may use separate form than the OAR)*

## Provider Requested Authorization Units – Please Sign Below

**On Begin Date of Sessions, Client is: ☐ Adult ☐ Child**
**Interpreter needed for these sessions: ☐No ☐Yes, Language:**Click here to enter text.

| Treatment | Begin Date of Sessions | # of Sessions | Frequency # Sessions per Wk/Mo/Yr | For Optum Care Advocate Sign Approved Service |
|---|---|---|---|---|
| Psychotherapy (max 12) | **10/13/2021** | **12** | **1x weekly** | |
| Group Psychotherapy (max 12, specify length of session) | | | | |
| Team Conference (99366 or 99368) | **10/13/2021** | **4** | **2x weekly** | |
| Other: | | | | |
| Other: | | | | |

**Provider Information**

| | | |
|---|---|---|
| Name/Licensure: Caring Provider, LMFT | Phone: 000-000-0000 | |
| Provider Signature: Caring Provider, LMFT Date:10/13/2021 | Fax: 000-000-0000 | If Modified or Denied, Date of NOA: _____ |
| If Group Practice, name of Group: | | |

**For Optum Care Advocate**

*If Request Modified or Denied, below sessions were authorized:*

| Authorized Treatment | Begin Date of Auth | # of Sessions | Frequency | Optum Signature |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |