ACT OTR FORM

Date: _____	Member Name: _____
☐ Initial Request	# Units requested: _____ CPT: H0039 Modifiers: _____
☐ Continued Stay/Requesting additional units Last authorization #: _____	
Date member initially start receiving services: _____ Units will be authorized at 1 unit per month.	Authorization Start Date: _____ Authorization End Date: _____

Member DOB:	Medicaid/Health Plan #:
Legal Guardian if not self:	Member Phone #:
Member Address:	City, State: _____ Zip: _____

Requesting Provider: _____ NPI#: _____ TIN#: _____ LMHP/MD Name: _____ Contact Name: _____ Contact Phone: _____ Contact Fax: _____ Contact Email: _____	Servicing Provider: ☐ same as requesting NPI#: _____ TIN#: _____ LMHP/MD Name: _____ Contact Name: _____ Contact Phone: _____ Contact Fax: _____ Contact Email: _____

DSM Diagnosis code:

ICD-10 Code:

Level of Functional Impairment: ☐ No Impairment ☐ Mild ☐ Moderate ☐ Severe

Risk of Harm to Self or Others: ☐ No Risk ☐ Mild ☐ Moderate ☐ Severe

Progress Towards Goals:

☐ N/A (initial request)

☐ Making Progress Towards Goals

☐ Lack of Adherence and/or Progress

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PLEASE SUBMIT THIS FORM WITH THE FOLLOWING ITEMS:

For initial authorization:

☐	An initial assessment that includes psychiatric history, mental status exam, diagnosis, and information needed to determine medical necessity and if the member meets eligibility criteria to receive ACT services.
☐	LOCUS scoresheet signed by an LMHP, on a form that includes the rating in each dimension, the criteria to support the rating, independent criteria, the composite score, the level of care, a section to document notes, a signature line with credentials, and a rating date.
☐	Initial Treatment plan (including goals with focus of treatment and transition/discharge plan) with signatures of member, team leader, and prescriber.
☐	Member Choice/Freedom of Choice Form

For continuing stay authorization:

☐	"Comprehensive person-centered needs assessment" updated every 6 months • The sections of the person-centered needs assessment shall be completed by ACT team members with subject matter expertise as indicated by their role within the program. • The entire assessment shall be reviewed and signed off on by the licensed mental health professional (LMHP)
☐	LOCUS score sheet signed by an LMHP, on a form that includes the rating in each dimension, the criteria to support the rating, independent criteria, the composite score, the level of care, a section to document notes, a signature line with credentials, and a rating date. Needs to be updated every 6 months.
☐	Treatment plan (including goals with focus of treatment and transition/discharge plan) updated every 3 months with signatures of member, team leader, and prescriber.
☐	ACT Transition Assessment Scale updated every 6 months
☐	Career Profile / Vocational assessment updated every 6 months
☐	Progress Summary completed within the past 30 days of the continuing stay authorization request. A Progress Summary shall include the following: • Document the time period summarized; • Indicate who was contacted, where contact occurred and what activity occurred; • Record activities and actions taken, by whom, and progress made; • Indicate how the member is progressing toward the personal outcomes in the treatment plan, as applicable; • Document delivery of each service identified on the treatment plan, as applicable; • Document any deviation from the treatment plan; • Record any changes in the member's medical condition, behavior or home situation that may indicate a need for a reassessment and treatment plan change, as applicable; • Be legible (including signature) and include the functional title of the person making the entry and date

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By my signature below, I hereby attest that all of the information above is true and accurate to the best of my knowledge.
Printed LMHP/Provider Name and Credentials: _____ _____ Signature of Provider/Clinician:

Submitted by:	Date:

Approved by OBH 1.23.2026