

**ASSERTIVE COMMUNITY TREATMENT (ACT)
INITIAL AUTHORIZATION REQUEST FORM**

To be Completed by OBH						<i>Revised 7.1.16</i>					
Tracking #						Date/Time of Receipt					
PROVIDER INFORMATION											
Provider Company Name											
Person Making Referral						Credentials					
Provider Phone #				Provider Email							
Provider Address											
CLIENT INFORMATION											
Recipient Name						SS#					
Age			DOB			Ethnicity					
Gender			Gender Expression				Marital Status				
Parent/Guardian						Phone #					
Address											
ACT INITIAL AUTHORIZATION REQUEST											
Admit Date						Requested Length of Stay					
Requested Start Date						Requested End Date					
Medicaid Status		Applied	<input type="checkbox"/>	Date Applied				Denied	<input type="checkbox"/>	Date Denied	
Medicaid Approval/Denial Explanation											
Presenting Problem											
Diagnosis											
ICD10 Code											
Current Medications											
Substances Using/Treatment											
Recent UDS, BAL											
Medical Problems (current/recent diagnosis)											
Supports											
Please outline the patient's current and past psychiatric and substance use history (including current diagnoses and symptoms, dates and locations of hospitalizations/ER visits, history and/or presence of suicidal/homicidal ideation, interactions with law enforcement due to mental illness/substance use, etc.).											
Comment											
What circumstances, assessment results, or referrals indicate the need for ACT at this time (<i>i.e.</i> , judicial or probation/parole recommendations, inability to meet basic needs, etc.)?											
Comment											