

**INTENSIVE OUTPATIENT (IOP)
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						
IOP 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; include illicit substances used, last use, duration and frequency						
Current Diagnosis (Psychiatric/SUD)						
ICD10 Code						
Current Psychotropic Medications						
Medical Diagnosis and Medications						
JUSTIFICATION OF IOP LEVEL OF CARE						
Withdrawal Status: Are the individual's detoxification needs severe enough to require an inpatient/residential level of care? Can the individual's withdrawal symptoms be managed in the community?						
Comment						
Medical Status: Does the individual present with acute (severe) medical problems? Is the individual medically stable to function in IOP? If there are medical needs, can they be managed in the community with supports?						
Comment						
Psychiatric Status: Can the individual's psychiatric symptoms be managed in the community with the appropriate psychiatric supports? Is the individual's cognitive ability sufficient <u>at this time</u> to benefit from admission to IOP? Has the individual demonstrated an ability to develop skills to manage symptoms or make behavioral changes?						
Comment						
Motivation Status: Does the individual demonstrate motivation to comply with the requirements of the treatment for management of symptoms and/or for successful behavioral change?						
Comment						
Relapse Potential Status: Does the individual's condition reflect a pattern of severe substance use as evidenced by periods of inability to maintain abstinence over a consistent period of time? Has the individual received Residential, Outpatient or Intensive Outpatient treatment?						
Comment						
Community Support Status: Is the individual able to seek professional supports and/or support from caretakers/guardians/family members outside of program hours as needed?						
Comment						
Provide information regarding treatment plan and discharge determination:						
Comment						