PerformCARE®

Targeted Case Management (TCM) Mental Health (MH) Authorization Request Form

☐ **Check here if Out of Network (OON): OON General Information Form, County approval letter, and a detailed rationale for utilizing an OON Provider including why an INN Provider is unable to meet the member's treatment needs must be included with your request.**

Member Information

Member Name: ________________________________ MAID: _________________ DOB: _______

Member Address: ____ Phone #: ____________

REL/SOGI (Complete each section and indicate if Member preferred not to answer).

Member's Race:____________________________ Member's Ethnicity:__________________________

Member's Sexual Orientation: _____________________ Member's Gender Identity:________________

Member's Assigned Sex at Birth:____________________ Member's Pronouns: _____________________

Member's Alternative Name (if applicable): __________________________

Member's Primary Language:

Written: _________________________ Spoken: __________________________

Provider Information

Provider Name: ____

Provider Address: ____ Phone #: ____________

Fax #: _______________ Person Completing Form: ____________________________________

TCM Name: _________________________________ TCM Phone #: ___________________

Check One: ☐ Blended ☐ ICM ☐ RC

Check One: ☐ Adult ☐ Child

Current Living Situation

☐ Independent	☐ PCBH/DOM Care/Assisted
☐ With Family	☐ CRR/Other Residential
☐ Supported	☐ RTF
☐ LTSR	☐ Other: ______________________________________

Is Member currently in a state hospital, prison/jail, detention, or nursing home? ☐ Yes ☐ No

If yes:

Date of admission?: ____________________________

Name of facility: ____

Address of Facility: ____

Did TCM notify DHS? ☐ Yes ☐ No

Diagnosis

Current diagnosis codes: ____

Check all that apply

☐ Co-Occuring (MH/SU) ☐ Autism Spectrum Disorder

☐ Dual Diagnosis (MH-ID) ☐ Forensic TCM (HX modifier)

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Matrix

Matrix score:

If Member does not meet matrix for the level of TMC requested, please explain below:

Referral Complete Date (Start Date of authorization): ______________________________

First Date of Service offered to Member: ______________________________

Note: Face-to-face or phone can be used for initial billable contact. Matric completion by the TCM is billable prior to the authorization start date

Exception granted for diagnosis or MNC Matric score by county administrator? ☐ Yes ☐ No

If yes, functional assessment instrument used: __________________________________ Score:

Comments: