City/County SAMSO Authorization Request Form

Ancillary Services

First Name:

Date of Birth:

Physical Address w/ Zip Code:

Cell Phone:

Last Name:       **[ ]** Male **[ ]** Female

SSN last 4 (if known):

Mailing Address (if different):

Email Address:

Agency Requesting Authorization:

Referral Source:       Date of Referral:

Previous Treatment (Dates and Types of Treatment):

Axis I Substance Use Primary Diagnosis, if known (ICD-10 or DSM-5):

Axis I Non-Substance Use Primary Diagnosis, if known (ICD-10 or DSM-5):

Motivation for Treatment: (Check one) **[ ]** High **[ ]** Medium **[ ]** Low **[ ]** Other: (Describe)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Substances Used:** | **Amount** | **Frequency** | **Duration** | **Last Use\*** |
| Primary:      |       |       |       |       |
| Secondary:      |       |       |       |       |
| Tertiary:      |       |       |       |       |
| *\*If last use is not in the recent past, please include an explanation in section one of the clinical information section.* |

Is the consumer currently receiving or referred to **case management** services?

Do not count your agency’s case management services unless it is funded by a source other than the SAMSO.

If client is receiving services from YFAC or the Children’s Partnership, list Care Coordinator below.

**[ ]**  Consumer is already receiving case management:

 Name of Case Manager:       Phone Number:

 Name of agency:

**[ ]**  I have referred consumer today to:

 Name of Case Manager:       Phone Number:

 Name of agency:

**[ ]**  Client refused referral

Type of Request (check one): **[ ]**  Initial **[ ]**  Concurrent **[ ]**  Extension

 **[ ]**  Step-down **[ ]**  Resubmission/Correction **[ ]**  Discharge Notice

Funding Source: **[ ]**  At Risk Adults

 the following require a referral from the funder:

 **[ ]**  Community Court **[ ]**  Family Drug Treatment Court **[ ]** ThriveCare of Travis County

 **[ ]**  Forensic SUD/SB 292 (individual must have criminal justice involvement and mental health diagnosis)

Begin Date for Requested Services:       or Discharge Date:

**Please Check Requested Service(s):**

**[ ]** Supported Transitional Housing - H0043

**[ ]** Self-Help/Peer Services – H0038

**[ ]** Self-Help/Peer Services, Group – H0038HQ

## Justification and/or Information for Reauthorization

(For reauthorization, include how client is benefiting, progress towards goals such as housing or employment, motivation level, need for further treatment and number of units requesting.)

Completed by:       Phone #:

**Please Upload the Completed Form to Integral Care’s FTP Website**

# CONTACT: Utilization Management (512) 440-4044