Banner University Health Plans
Banner – University Family Care

OUT-OF-HOME (OOH) APPLICATION

This request is to be completed (typed) and submitted with the Behavioral Health Prior Authorization.

Send by Fax to:

BUHP Behavioral Health Prior Authorization Department at (520) 694-0599.

This form must be accompanied by the Behavioral Health Prior Authorization Form.

All fields must be filled out. Incomplete or handwritten forms will be returned to sender.

Date of Request:_____ **Request for:** Adult ☐ Child/Adolescent ☐

Request: ☐ Behavioral Health Residential Facility (BHRF) ☐ Therapeutic Foster Care/Adult BH Therapeutic Home

☐ Behavioral Health Inpatient Facility (BHIF/RTC)

Member's Name:_____ **Age:**____ **DOB:**_____

AHCCCS ID: _____ **Gender:** _____

Member's Primary Language: ☐ English ☐ Spanish ☐ Other (specify): _____

Legal Status (Adults only) ☐ COT ☐Voluntary

Are all ART/CFT members in agreement of this level of care? ☐ Yes ☐ No

Behavioral Health Category: ☐ GMH ☐ SU ☐ Child **Funding Source:** ☐ T19 ☐ T21

Where is the member currently living? ☐ Home ☐ DOC ☐ House ☐ Jail ☐ Respite ☐ Shelter

☐ Other: _____

If other than home – admission date: _____

Facility: _____

Name of the proposed OOH Facility: _____

Address: _____

Further information can be found on the Behavioral Health Comprehensive Provider Manual Supplement

If applicable

Legal guardian: _____ **Phone #:** _____ **Ext:** _____

Fax #: _____

Street address: _____ **City:** _____

State: _____ **Zip Code:** _____

Legal guardian's primary language: ☐ English ☐ Spanish ☐ Other (specify): _____

Requesting Outpatient Provider Agency: _____

Name of person completing request: _____ **Phone #:** _____ **Ext:** _____

Staff email: _____ **Fax #:** _____

Clinical Director Name: _____

Signature: _____ **Date:** _____

Why is an out of home intervention being requested at this time?

_____

_____

_____

_____

_____

_____

_____

_____

Who will be involved with member's treatment? Family, friends, supports

_____

_____

_____

What outpatient services have been tried? CHECK ALL THAT APPLY.

_____

☐ None	☐ Home-based therapy	☐ Peer support
☐ Behavior Coach	☐ Independent living skills	☐ Respite
☐ Crisis stabilization team	☐ Individual counseling	☐ Skills training and development
☐ Dialectical Behavior Therapy (DBT)	☐ Medication management	☐ Substance abuse IOP
☐ Family counseling	☐ Other in-home services	☐ Vocational assessment & training
☐ Functional Behavioral Analysis (FBA)	☐ Parent partner	☐ Other:

Further information can be found on the Behavioral Health Comprehensive Provider Manual Supplement

Measurable Goals for this Out of Home Admission:

Specify the SMART goals the member will accomplish at the treatment facility. (Specific, Measurable, Achievable, Relevant and Time Based)

Goal:	Objectives:

Required documentation checklist for OOH Admission request: (to be included)

****Please note: OOH request will not be reviewed without the following documentation. ****

☐ ART/CFT notes for the past 30 days

☐ ASAM if request is for OOH substance abuse treatment

☐ Current Complete Care Plan (must be updated with requested service identified in the plan)

☐ Most recent psychiatric evaluation or psychiatric progress note and medication notes

☐ Psychiatric progress notes for the last 30 days

☐ Medical/physical status/orders/progress notes, (including rationale for personal care services)

Further information can be found on the Behavioral Health Comprehensive Provider Manual Supplement