Level III Eligibility Review (effective 10/1/2020)

Complete the form below to consider Level III eligibility for youth currently enrolled in Level II services. This document is intended to supplement required documentation expectations (e.g., contact notes).

Youth Name: _____

Current Auth. Start/End Dates: Start Date: _____ End Date: _____

Level III Eligibility as of 10/1/2020:

- Date of Internal Review: _____
- Please check all criteria the youth currently meets:
  - ☐ The participant has a behavioral health disorder amenable to active clinical treatment, resulting from a face-to-face psychosocial assessment by a licensed mental health professional
  - ☐ Children ages 0-5 must meet one of the following criteria:
    - Be referred directly from an inpatient hospital unit; or
    - If living in the community, have one or more psychiatric hospitalizations or emergency room visits in the last 12 months
  - ☐ Youth ages 6-21 must meet one of the following criteria:
    - Be transitioning from a residential treatment center; or
    - Be living in the community and:
      - Have any combination of 2 or more inpatient psychiatric hospitalizations or emergency room visits in the past 12 months; or
      - Have been in an RTC within the past 90 days
- Eligible:
  - ☐ Yes (proceed to next step)
  - ☐ No (discontinue/document and file)

Caregiver Discussion:

- Date of Discussion: _____
- Caregiver agreement with increasing level of care to Level III:
  - ☐ Yes (proceed to next step)
  - ☐ No (discontinue/document and file)
    - Reason for Declining:
- Caregiver agreement with 1915i Referral:
  - ☐ Yes (proceed to next step)
  - ☐ No (if agreed to Level III, proceed to next step)
    - Reason for Declining:

Behavioral Health Provider Discussion:	• Selected 1915i Supplemental Support Services Providers: • Intensive In-Home Services: _____ • Community Based Respite Care:_____ • Out-of-Home Respite Care:_____ • Family Peer Support:_____ • Expressive and Experiential Behavioral Services:_____ • Discussion requesting updated Psychosocial Assessment Date: _____ • Date updated Psychosocial Assessment Received: _____
LBHA Referral:	• Date of Referral to LBHA: _____ ○ Be sure to include the initial CCO Referral form, updated Psychosocial Assessment, Youth's Social Security Number (if accessing 1915i) and identified/requested behavioral health provider(s) listed above
LBHA Approval:	• Date of Approval by LBHA: _____ • Approval Forwarded to ASO by LBHA: ☐ Yes (proceed to next step) ☐ No (Contact LBHA)
ASO Approval:	• Date of Level III Approval by ASO: _____ • Date of 1915i Approval by ASO: _____
Care Coordinator Signature/Date:	Printed Name: _____ Signature: _____ Date: _____
Care Coordinator Supervisor Signature/Date	Printed Name: _____ Signature: _____ Date: _____