

SECTION I

MCO (check one) ☐ **Anthem** ☐ **Beacon/Humana** ☐ **Virginia Premier**

Individual's Name:	ID#:	Current Assessment Date:
Individual's Address:		
Initial Admission Date to ICT:	Initial Assessment: ☐	Subsequent Assessment: ☐

Request for approval of ICT Service from (date) _____ to (date) _____ for a total of ____ units of service.

Diagnostic Information	List of Known Medical Conditions
Axis I:	
Axis II:	
Axis III:	
Axis IV:	
Axis V:	

List of Current Medications Prescribed				
Name of Medication	Dosage	Frequency	Name of Prescriber	Past Medication Compliance Issues
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

SECTION II

Does the individual have an Integrated Care Plan that was designed by the MCO Care Team?
☐ Yes (Proceed to Section IV) ☐ No (Complete Sections III and IV).

SECTION III

Mental Health Issues/Needs		
Initial Problem-Present Situation: <i>Current Level of Functioning (including symptoms over the past 6 months, impact of symptoms on overall functioning and participation in treatment plan/services)</i>		
A. Identify areas of need:		
B. Assess level of support (family, payee services, others living in household):	<i>Change since last assessment?</i>	☐ Yes ☐ No
C. Address need and appropriateness of ICT <i>(Psychiatric, Substance Abuse, Medical, behavioral, Social Functioning and Support, Shelter, Income, Vocation, Academics, and Instrumental Functioning):</i>		

ELIGIBILITY CRITERIA	
I. Intensive Community Treatment Eligibility Criteria	
Diagnosed with a severe and persistent mental illness (required)? Specify:	☐ Yes ☐ No

At least one of the following must be present, with impairment on an intermittent or continuing basis without intensive community support	
Inability to consistently perform practical daily living tasks required for basic adult functioning in the community. Specify:	☐ Yes ☐ No
Persistent or recurrent failure to perform daily living tasks except with significant support or assistance by family, friends, or relatives.	☐ Yes ☐ No

Specify: Inability to be consistently employed at a self-sustaining level of inability to consistently carry out homemaker roles.	☒ Yes ☒ No
Specify: Inability to maintain a safe living situation.	☒ Yes ☒ No

The individual must also have high needs due to at least one of the following problems.	
Resides in a state mental health facility or other psychiatric hospital, but clinically assessed to be able to live in a more independent situation if intensive services were provided or anticipated to require extended hospitalization if more intensive services are not available. Specify:	☒ Yes ☒ No
High user of state mental health facility or other acute psychiatric hospital inpatient services within the last two years or a frequent user of psychiatric emergency services are not available. Specify:	☒ Yes ☒ No
Intractable, (i.e., persistent or very recurrent). Severe major symptoms (e.g., affective, psychotic, suicidal). Specify:	☒ Yes ☒ No
Co-occurring substance addiction or abuse of significant duration (e.g., greater than six months). Specify:	☒ Yes ☒ No
High risk or a recent history of criminal justice involvement (e.g. arrest or incarceration within the past six months). Specify:	☒ Yes ☒ No
Unable to meet basic survival needs or residing in a substandard housing, homeless or at imminent risk of becoming homeless. Specify:	☒ Yes ☒ No
Unable to consistently participate in traditional office-based services. Specify:	☒ Yes ☒ No

II. MEDICAID Criteria (Required to bill Medicaid)	
Individual is best served in the community (Required); Specify:	☒ Yes ☒ No

The individual must also have high needs due to at least one of these Medicaid criteria.	
Is at high-risk for psychiatric hospitalization or for becoming or remaining homeless or requires intervention by the mental health or criminal justice system or to inappropriate social behavior. Specify:	☒ Yes ☒ No
Has a history of (three months or more) of a need for intensive mental health treatment or treatment for serious mental illness and chemical addiction and demonstrates a resistance to seek out and utilize appropriate treatment options. Specify:	

SECTION IV

Signature of QMHP Date

I attest to reviewing this assessment and approve the authorization of Intensive Community Treatment Services:

Signature of LMHP Date

Community Services Board:

FAX COMPLETED FORM TO THE MCO INDICATED IN SECTION I ABOVE, USING THE APPROPRIATE FAX NUMBER BELOW

Anthem: 1-800-505-1193
Humana/Beacon: 1-855-765-9705
Virginia Premier/Magellan Commercial: 1-866-354-8758