QUESTIONNAIRE FOR ADMISSION CRITERIA FOR LEVEL A AND B COMMUNITY BASED SERVICES CRITERIA

INSTRUCTIONS

This questionnaire has been designed to include the basic information that KePRO needs to process requests for these services. While not mandatory, it is expected that use of the questionnaire by providers will decrease the number of requests pended for additional information and provide a quicker turn around time.
This questionnaire allows for easy submission via iEXCHANGE, KePRO's Web-based Prior Authorization system. Please answer each question fully and completely. If more space is needed to answer any questions, please use the "Additional Information" space. Providing all of the requested information necessary to review your request will decrease the chance of it being pended for additional information and expedite the authorization decision. Please type or print neatly to prevent return of form and delaying determination

QUESTIONS

1. Did the recipient exhibited impairment in functioning within the last week?
YES☐ NO☐. If yes, describes behaviors in the last week.

2. Have there been failed treatments within the past month? YES☐ NO☐.
If yes, what treatments/services were tried? Failed?

3. Does the recipient have a support system? YES☐ NO☐.
If yes, please describe.
If no, please explain.

4. Does the Initial Plan of Care (IPOC) contain **all the required elements** including dated signature of QMHP (Level A)? or LMHP (Level B)? YES☐ NO☐.

   a. Start of Care Date *(use MM/DD/YYYY format):* _________________

   b. Completion of IPOC Date *(use MM/DD/YYYY format):* ___________

CERTIFICATE OF NEED (CSA REQUESTS ONLY)

   a. Is the CON signed/dated by the Physician and 3 members of the FAPT?
   YES☐ NO☐.

   b. Date CON completed *(use MM/DD/YYYY format):*__________________

PRE-SCREENING FORM (PSF) (NON-CSA REQUESTS ONLY)

   a. Is the PSF signed and dated by physician and Licensed Mental Health Provider (LMHP)? YES☐ NO☐.

b. Date PSF completed *(use MM/DD/YYYY format):* ___________________

CAFAS/PECFAS (CSA REQUESTS ONLY)

a. Is there a CAFAS/PECFAS? YES☐ NO☐. If yes, completion date *(use MM/DD/YYYY format)* _____________

b. Are there at least 2 moderate impairments? YES☐ NO☐.

ASSESSMENT-EPSDT (NON-CSA REQUESTS ONLY)

a. Is there an assessment completed by the EPSDT provider and independent LMHP? YES☐ NO☐. If yes, completion date *(MM/DD/YYYY):* __________

b. At least 2 moderate impairments? YES☐ NO☐.