

Region IV Acute Care Project Project Admission & Initial Payment Authorization

Initial Project Admission []
Readmission []

With: (hospital/facility): _____ Date: _____ Authorizing CSB/BHA: _____

AND: Treating Psychiatrist: _____

AND: Client: _____ Gender: M / F Age: _____

Soc.Security or Client ID #: _____ DOB: _____

Address: _____ City: _____ State: _____ ZIP: _____

DX(s): (Axis I) _____ Code(s): _____

(Axis II) _____ Code(s): _____

(Axis III) _____ Code(s): _____

(Axis IV) _____ Code(s): _____

(Axis V) _____ Code(s): _____

Voluntary [] Pursuant to TDO [] Hospital Admission Date: _____

Project Admission Date: _____

Number of Days Authorized: _____

Initial Authorization not to exceed 5 Days – Extensions require approval of participating CSB/Authority and submission of Reauthorization form

Check Admission Criteria Met: _____

Diagnosis or suspected diagnosis of Mental Illness
– **and one of the following:**

Behavior reflecting suicide attempt or intent with a plan

Imminent danger to self and / or others is apparent

Clinical manifestations, symptoms or complications so severe as to preclude assessment & treatment in less intensive setting and requires 24-hour nursing / medical assessment, intervention & monitoring. Less restrictive or less intense approaches not effective.

Impairment exists to degree that individual is unable to care for him or herself and is therefore an imminent danger to him or herself

The client identified above is being referred to your facility for acute psychiatric in-patient treatment. Payment will be made by the referring Community Services Board / Behavioral Health Authority as per the Regional Agreement. This includes per diem rates for psychiatric care and in-patient services. Any other charges, including those for non-psychiatric medical problems, are specifically excluded. The referring Community Services Board/Behavioral Health Authority shall determine the client's eligibility for extended admission under the project.

CSB/BHA Project CM: _____ Telephone: _____ Pager: _____

Is Case Open to CSB/BHA? Yes No If yes, CSB/BHA admission date: _____

Known History of State Facility Admission(s)? Yes No

Project Admission Approval CSB/BHA Authorizing Representative: _____
(Signature)

Copy(s) with Copy of Pre-Admission Screening Form to:

CSB/BHA

Admitting Hospital

Regional Authorization Committee

c/o John P. Lindstrom, RBHA
804-819-4265 (Fax)