Psychiatric Rehabilitation Services Adult- Continued Stay Review

Date: _______________

Consumer Name: _________________ DOB: ___________ MA ID#: _________________________

Provider Contact Name: ______________________ Provider: Contact Phone# ______________________

Requested Services: On-site ___________ Off-site ____________ Blended____________________

Requested Start Date for this Authorization: ____

Please remember to upload the most recent referral form from the treating clinician or list the clinician's name with credentials and the last date of collaboration: ____

____

Skills the consumer requested to support his/ her recovery: ______________________________________

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Skills that will be addressed within this authorization period in the individualized recovery plan:
____

____

Detail the progress the consumer has made in meeting his/her rehabilitation goals since the previous review: ____

____

Recovery Supports/ Needs he/she has identified for successful discharge: __________________________

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Current Support Systems (Natural and Community)? ____

Planned service (s) after psychiatric rehabilitation: ____

What are the barriers preventing the consumer from transitioning to a lower level of care and how is this being addressed: ____

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