

Department of Health and Welfare
Family and Community Services
Retroactive CRISIS AUTHORIZATION Request

Per Idaho statute 16-1602: If the child is without parental care and control the agency must report this to Child Protective Services (CPS). The Medicaid Children's Developmental Disability (DD) program crisis benefit is not designed to replace parental care and cannot reimburse for care provided by an agency if the child is without parental care. This document must be submitted to the Department within 72 hours of providing the service. Please fax to the child's Case Manager.

Provider Agency:		Staff Requesting:	
Child's Name:		Date Requested:	
Crisis Information			
Date of crisis:	Time began:	Time end:	Total time:
SSN:	MID:	Age:	Gender:
Current Living Situation (Check one): <input type="checkbox"/> P-Lives with parents/stepparents <input type="checkbox"/> FH- Foster home <input type="checkbox"/> R-Live with relatives <input type="checkbox"/> Other, please specify:			
Please identify why the agency is requesting crisis (check one): <input type="checkbox"/> Hospitalization <input type="checkbox"/> Loss of housing <input type="checkbox"/> Loss of employment <input type="checkbox"/> Incarceration <input type="checkbox"/> Physical harm to self or others, including family altercation or psychiatric relapse Please explain the unanticipated event, circumstance or life situation that places child in need of crisis services:			
How were the crisis service utilized?			
Please list all other means of supports the agency identified and reasons why they were unable to assist with the child's crisis (16.03.10.683.06.d.i). Was CPS called at 1-855-552-5437? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list name and date and their response:			
Crisis Hours Requested:		Crisis Intervention Technician (H2011 HA)	
Number of units:	Start date:	End date:	
This section to be completed by Case Manager			
Crisis Hours Authorized: Number of units _____		Crisis Intervention Technician _____	
Start date:	End date:	Prior Authorization #	
Recommendations for further assessment/ prevention of reoccurrence:			
Crisis Hours Denied: Number of units denied _____		Explanation for denial:	
_____		_____	
Case Manager Signature		Date:	

INSTRUCTIONS

Complete form in detail. Attach supporting documentation for the crisis service provided. Documentation to include: date and time of services, intervention and support service provided, child's response to service, length of visit including time in time out, and specific place of service according to IDAPA 16.03.10.684.

RETROACTIVE REQUEST PROCESS

- Upon receipt the Case Manager has (3) business days to make a determination on the request or notify the provider of missing information.
- When the provider receives the notification, they have (3) business days to submit the missing information to the Case Manager.
- The request will be "CLOSED" if the Case Manager does not receive the identified information within (3) business days.
- The Case Manager has (3) business day hours to make the determination and notify the provider.

OUT OF HOME PLACEMENT

Per IDAPA 16.03.10.168.06.i Any out of home placement must be prior authorized by the Department.