## REQUEST FOR ADDITIONAL CRISIS SERVICE COORDINATION HOURS

Additional Community Crisis Service Coordination hours are requested in order to facilitate access to

emergency community resources, by linking/coordinating, and/or advocating for services. Please complete this form and forward to Behavioral Health Care Management. Participant Name: \_\_\_\_\_\_ Number of Hours Requested: \_\_\_\_\_ Medicaid Number:\_\_\_\_\_\_\_
Service Coordinator:\_\_\_\_\_\_ Start Date:\_\_\_\_\_End Date: \_\_\_\_\_\_ Provider # Participant must meet all of the following criteria: ❖ Imminent risk (within 14 days) of hospitalization or institutionalization; and **Experiencing symptoms of psychiatric decompensation; and** \* Received the maximum number of monthly hours of ongoing and crisis service coordination; and \* No other crisis assistance services are available under other Medicaid mental health option services (including) Psychosocial Rehabilitation Services Crisis must be precipitated by an unanticipated event, circumstance, or life situation that places the participant at risk of: (check all that apply) Hospitalization Losing employment or major source of income Physical harm to self or others Incarceration (family altercation or psychiatric relapse) Becoming homeless Please document the following information in detail. Attach the service coordination assessment and treatment plan and any applicable progress notes. 1. Presenting Problem: A. Date crisis began: B. Describe the crisis, include the unanticipated event or circumstance that led to the crisis. C. What symptoms of psychiatric decompensation are present?

## 2. Crisis Response History:

MONTH TO	DATE TOTALS: Ongoing Service Coordin	ation Crisis Service Coordination
A.		rvices have already been provided to resolve this vice coordination and crisis units or hours already
В.	How does this intervention promote the heat hospitalization/incarceration/out of home page 1	· · · · · · · · · · · · · · · · · · ·
3. Crisis R	Resolution Plan:	
A.	Action Plan: What is your agency's response to resolving the crisis? (Be specific and identify what linking, coordinating, or advocacy services will be provided.)	
В.	B. How does this intervention promote the health and safety of the recipient or prev hospitalization/incarceration/out of home placement?	
Participant Name:		Agency Name:Phone Number:
Signature of Service Coordinator:		Fax Number:
Date:		E-Mail Address: