

Interim Housing



Group A

ADULT MENTAL HEALTH DIVISION

****THIS REQUEST MUST BE ACCOMPANIED BY A CURRENT LOCUS****

PURPOSE

To promote the appropriate level of services and treatment for registered consumers.

Fax Completed Form To: AMHD Utilization Management

Phone Number: 586-7400 Fax Number: 733-1349 Fax Date: _____

Use an X mark in the boxes as appropriate.

Reason for form completion:

Admission Continued Stay Discharge

CONSUMER INFORMATION (Type or Print Clearly)

Name: _____ Alias: _____

Date of Birth: _____ SSN: _____ Phone: _____

Address: _____

City: _____ State: HI Zip Code: _____

Current DX Code, Axis I: _____ Current DX Code, Axis II: _____

Axis III: _____ Axis IV: _____ Axis V: _____

Other Benefit Coverage: _____ Policy #: _____

PROVIDER CONTACT INFORMATION

Provider Agency: _____ Submitted by: _____

Provider Phone: _____ FAX: _____

Address: _____ City: _____

State: HI Zip Code: _____

Case Management Agency/Level of Care: _____

Case Manager: _____ Phone: _____

Name of Consumer: _____ Interim Housing

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Admission Criteria

Admit Date:

Meets **all** of the following:

1. Eligibility criteria:
 - a. Is eligible and receiving services from the Division;
 - b. Is a potential consumer who has a scheduled assessment for eligibility for Division services.

2. Low risk of harm to self or others;

3. Functional status shows at least limited ability to fulfill social responsibilities/ interpersonal relationship/ability to care for self;

4. Either no medical or substance abuse co-morbidity exists or the presence of such does not require close medical monitoring;

5. Environmental issues as evidenced by at least **one** of the following:
 - a. Severe disruption in life circumstances such as lack of permanent residence or imminent incarceration.
 - b. Episodes of victimization or direct threats of violence near current home.

6. Either no supports exist in the community or existing supports are unable to provide sufficient resources to meet consumer needs;

7. Treatment and recovery history indicate **one** of the following:
 - a. No knowledge of previous treatment and recovery history.
 - b. History indicates some success when treatment has been provided.

8. Consumer shows at least limited desire or commitment to accept responsibility for recovery;

Continued Stay Criteria

Continued Date:

Meets **all** of the following:

1. Observation and care in the management of disturbance of mood, thought, or behavior continue to be effectively managed in this setting;

2. Consumer is being actively linked with appropriate community resources;

3. Consumer is actively involved with case management services and in planning for transition out of this service.

Name of Consumer: _____ Interim Housing

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Discharge Criteria

Discharge Date: _____

Meets **one** of the following:

1. Consumer is eligible for Division services and has been linked to appropriate services, including either residential treatment or housing services.
2. Consumer is not eligible for Division services and has been referred to appropriate services in the community.
3. Consumer voluntarily withdraws from the service.

Additional Discharge Reasons:

- Deceased
- Transfer to State Institution**
- Moved from Hawaii
- Transfer to another AMHD Funded Program*
- Closed – Unable to Locate / No Contact

Other: _____

* Includes change in LOC.

** Includes incarceration or long-term hospitalization.

Discharged to (Case Manager and Housing Disposition): _____

Service Exclusions

1. Consumers are not eligible for any other residential treatment or housing services while in this service; however, consumers will not lose their housing if they need this service for a short period of time. Consumers not yet determined to be eligible for Division services can receive only other crisis services until eligibility determination occurs.

Clinical Exclusions

The following consumers would not be appropriate for interim housing:

1. Consumers who show significant risk of harm to self or others.
2. Consumers whose co-morbidity problems cannot be safely managed at this level.
3. Consumers who are clearly not likely to be diagnostically eligible for Division services.
4. Consumers who are extremely avoidant, frightened, or guarded.
5. Consumers who would be safer in a higher level of crisis services.

Name of Consumer: _____ Interim Housing

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Justification for request despite exclusions:

Attestation below for Group A Services Only

I ATTEST THAT THE SERVICE REQUESTED IS CLINICALLY NECESSARY FOR THE ABOVE NAMED CONSUMER.

QMHP Name: (PLEASE PRINT) _____

License Type: _____ Date Signed: _____

Phone: _____ FAX: _____

QMHP Signature: _____