

Consumer Name (PRINT): \_\_\_\_\_ CBI/CRF  Group A

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**COMMUNITY BASED INTERVENTION (CBI) WRAP AND NON-WRAP  
AND CONSUMER RESOURCE FUND (CRF) AUTHORIZATION FORM**

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

**PURPOSE**

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

**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: \_\_\_\_\_

Case Management Agency/Level of Care: \_\_\_\_\_

Case Manager: \_\_\_\_\_ Phone: \_\_\_\_\_

Use an X mark in the boxes  as appropriate.

**TYPE OF REQUEST: (please check one):**

Community Based Intervention Non-Wrap (CBI) Wrap

Community Based Intervention Wrap (CBI)

Consumer Resource Fund (CRF)

Consumer updated Financial Information

Hours Requested: (Please Specify)

Number of hours \_\_\_\_\_ / day \_\_\_\_\_

Number of Days per week \_\_\_\_\_

Amount Requested: (Please specify)

\$ \_\_\_\_\_

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**CRF or CBI Non-Wrap requests:**

1. Reason for request (rent, security deposit, etc.).

\_\_\_\_\_

2. Reason consumer is unable to pay this expense.

\_\_\_\_\_

\_\_\_\_\_

3. Document all other resources where you attempted to obtain monies and the result of attempts.

\_\_\_\_\_

\_\_\_\_\_

4. Consumer's monthly income (amount/source).

\_\_\_\_\_

\_\_\_\_\_

5. Consumer itemized monthly expenses: (include all monthly expenses consumer will expect to pay in an average month).

Item	Expense

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**CBI Wrap requests:**

1. Justification for number of hours:

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2. Expected duties of Wrap provider:

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3. Expected outcomes:

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Use an X mark in the boxes  as appropriate.

**CBI Admission Criteria**

Choose I or II of the following:

**I. One-to-One Wrap**

1. Meets **all** of the following:

- a. Identified specific self-care or self-regulating limitation which service will address;
- b. Measurable outcomes of how service will assist consumer is documented;
- c. No other community supports or resources available to provide this assistance;
- d. Reasonable likelihood that service will increase functioning or maintain stabilization.



## **II. Non-Wrap Services**

### 1. Meets **all** of the following:

- a. Identified specific and documented psychiatric or medical need for which the service is requested;
- b. Measurable outcomes of how goods or service will assist consumer is documented;
- c. No other financial means of paying for the goods or service;
- d. No other community resource provides the goods or service.

## **CRF Admission Criteria**

### **Meets all of the following:**

- 1. Consumer is actively engaged in housing and/or vocational pursuits that are designed to increase recovery and independence;
- 2. Other funding sources have been contacted and the consumer does not qualify for assistance through the other agencies/programs;
- 3. The request is anticipated to be a one-time request and is not for maintenance of either housing or vocational on a long-term basis;
- 4. Request is included in the treatment plan and consumer is in agreement with the request.

## **CBI Continued Stay Criteria**

Choose I or II of the following:

### **I. Wrap One-to-One**

#### 1. Meets **all** of the following:

- a. Continues to meet initial criteria;
- b. Identified specific self care or self regulating limitations continue to justify this service;
- c. Titration has been considered.

### **II. Non-Wrap Services: No continued stay.**

**CRF Continued Stay Criteria: *There is no continued stay. All requests are considered and reviewed as initial authorization requests.***

## **CBI Discharge Criteria**

Choose I or II

### **I. Wrap One-to-One**

#### 1. Meets **one** of the following:

- a. Identified self-care or self-regulation has improved and this service is no longer needed.
- b. Consumer needs a higher level of care and the new services will provide similar assistance.

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**II. Non-Wrap Services**

a. Services/goods have been provided.

**CRF Discharge Criteria**

Discharge occurs after the service has been rendered.

**CBI Service Exclusions:**

- 1. Services would not be appropriate for consumers in inpatient setting.
- 2. Wrap One-to-One should not be used as a substitution for higher level of care services, such as inpatient or specialized residential.
- 3. Consumers receiving Peer Support services would not normally be authorized for One-to-One Wrap.

**CRF Service Exclusions:**

- 1. CRF Funds are not used for medication.
- 2. Personal assistance.
- 3. One-to-one wrap around services.

**CBI and CRF Clinical Exclusions:** No specific clinical exclusions.

Provide clinical justification for this expense if it is not listed in the acceptable criteria above:

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**Complete this section for Only CBI Non Wrap and CRF.**

Name of Provider of Services: \_\_\_\_\_

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Check Written To (If different from Name of Provider): \_\_\_\_\_

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Mailing Address: \_\_\_\_\_

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CONSUMER NAME ON MEMO OF CHECK:  YES  NO

Submit the following documents with this request:

**CBI Non-Wrap or CRF:** Treatment Plan (The treatment plan must contain CBI/CRF as an intervention and indicate that the case manager will monitor the re-payment); LOCUS; Repayment Plan; and DOH Consent form allowing information to be shared with Egami & Ichikawa, CPAs.

**CBI Wrap:** Treatment Plan (The treatment plan must contain CBI Wrap as an intervention and include wrap duties as well as expected outcomes); LOCUS; and DOH Consent form allowing information to be shared with Egami & Ichikawa, CPAs.

**Remember:** Updates on the treatment plan must be signed and dated by the consumer and case manager.

**Complete this section for all CBI/CRF requests:**

Requested by: \_\_\_\_\_ Title: \_\_\_\_\_

Approved by CMHC Manager or Requestor's Supervisor: (PLEASE PRINT)

Signature of Supervisor: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_

**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 Submitted: \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

QMHP Signature: \_\_\_\_\_

**COMMENTS** (For AMHD UM use only)

Approved By: \_\_\_\_\_ Date : \_\_\_\_\_