

LIPOS PRIVATE BED / PHP – EXTENSION AUTHORIZATION

EHR # _____

Today's Date: _____ ***Extensions beyond 6 days require approval by MH Director or designee***
Extension at 3 days 6 days 9 days Other _____ (please note # days)

Client Information

1. First Name: _____ 2. MI _____ 3. Last Name _____

4. Social Security Number: ____/____/____ 5. Admission Date: ____/____/____

6. Hospital / Partial Hospitalization Program: Dominion INOVA – Loudoun INOVA – Mt. Vernon
 INOVA – Fairfax Prince William Virginia Hospital Center Snowden Poplar Springs
 Spotsylvania Out of Area _____

7. Authorizing CSB: Alexandria Arlington Fairfax Loudoun Prince William

Reauthorization not to exceed 3 days. Extensions require approval of participating CSB and submission of additional extension reauthorization forms as indicated.

Hospital Admission Only:

8. Authorizing Criteria Met: (check all that apply)

- 1) Confirmed Diagnosis of mental illness, and/or
- 2) Clinical evidence indicates persistence of symptoms that caused initial admission, or remain despite therapeutic efforts, or due to the emergence of new symptoms (daily progress note required), and/or
- 3) Severe reaction to medication or further monitoring/adjustment of dosages (daily progress note required)

9. Level of Care needed: Level I (Acute Stabilization) Level 2 (Intensive Care)

Level I – Acute Stabilization

- High acuity, **low** complexity
- Substance-induced symptomatology
- Situational crises resulting from psychosocial stressors
- Situational difficulties resulting from Axis II symptomatology
- Stopped taking medications or in need of medication adjustment (with history of good response to medication)

Level 2 – Intensive Care

- High acuity, **high** complexity
- Current lack of willingness or ability to participate in treatment
- Long-term, persistent or recurrent psychiatric difficulties
- Complex discharge issues (i.e., homelessness, lack of social support)
- May include medical co-morbidity

10. Has transfer to NVMHI been initiated? yes no If yes, date of request for transfer ____/____/____

11. NVMHI Contact: _____

The client identified above is referred to your facility for continued acute inpatient / Partial Hospitalization treatment as per the terms and conditions of the LIPOS Regional Acute Bed Purchase Project. Payment will be made per the LIPOS agreement. The referring Community Services Board shall determine the client's eligibility for extended admission under this project.

Partial Hospitalization Only:

12. Hospital Diversion Authorizing Criteria Met: (check all that apply)

- 1) Confirmed Diagnosis of mental illness, and/or
- 2) Meets clinical criteria for Temporary Detention Orders, or
- 3) Is at risk of psychiatric hospitalization on the basis of meeting at least two of the Medicaid eligibility Criteria for Crisis Stabilization listed below:
 - Experiencing difficulty in maintaining normal interpersonal relationship to such a degree that he/she is at risk of hospitalization or homelessness because of conflicts with family or community.
 - Experiencing difficulty in activities of daily living such as maintaining personal hygiene, preparing food, and maintaining adequate nutrition or managing finances to such a degree that health or safety is jeopardized.
 - Exhibiting such inappropriate behavior that immediate interventions by mental health and other agencies are needed
 - Exhibiting difficulty in cognitive ability such that he/she is unable to recognize personal danger or unable to recognize significantly inappropriate social behavior

13. Hospital Step-Down Authorizing Criteria Met:

- Client continues to require the additional treatment and support provided by the PHP in order to maintain stability in the community.

The CSB Discharge Planner may grant the first project reauthorization approval for up to 3 days. The Mental Health Director or designee may grant reauthorization approval in increments of up to 3 days thereafter.

13. Project Reauthorization for (# up to 3) ____ days to (date of review) ____/____/____

15. Authorizing Representative: _____ Date: ____/____/____