Magellan HEALTHCARE SM

Community Treatment Aide Request Form
Fax to Magellan: 1.888.656.1859

MAGELLAN BEHAVIORAL HEALTH OF NEBRASKA
REQUEST FOR PREAUTHORIZATION/CONTINUED STAY FOR COMMUNITY TREATMENT AIDE

INSTRUCTIONS: The referring mental health practitioner (treating clinician) must complete this application for the client he/she is referring for community Treatment Aide (CTA). For both admission requests and continued stay review, please complete this cover sheet and submit the client's individual treatment plan and the Magellan CTA Plan. Incomplete applications will result in delays in review by Magellan Behavioral Health.

Please submit this application and all supporting documentation to:
Magellan Behavioral Health of Nebraska
ATTN: CTA Reviewer
1221 N Street
Suite 325
Lincoln, NE 68508

If you have any questions, please call Magellan at (800) 424-0333.

CTA Provider Name: _____

Provider MIS# Number: _____

Mailing Address: _____

City / State / Zip: _____

Phone Number: _____

Fax Number: _____

Signature of Treating Clinician: _____

Signature of Supervising Practitioner: _____

Date: _____

MAGELLAN BEHAVIORAL HEALTH OF NEBRASKA
REQUEST FOR PREAUTHORIZATION/CONCURRENT REVIEW FOR COMMUNITY TREATMENT AIDE

Client Name: _____

Client Date of Birth: _____

Client Medicaid #: _____ **Client Social Security #:** _____

Client Legal Guardian Name: _____ **Phone Number:** _____

Number of units / week of CTA *previously* authorized (if applicable): _____

Number of units / week Requested: _____ **Total Number of Units Requested**: _____

From (date): _____ **To (date):** _____

Estimated Length of Stay (from date of request): _____

Diagnosis: _____

Current Living Situation/Placement: _____

Current Treatment (if child/family in more than one type of treatment, e.g. both individual therapy and family therapy, *please list separately*):

Begin Dates	Treatment Type	Provider	Phone Number	Frequency of Sessions

Name of Treating Clinician:	
Name of Supervising Practitioner:	

How will CTA services improve the child's capacity for living in the least restrictive environment?

How are CTA services expected to improve the child's mental health condition?

Where will the CTA services be provided (list all)?

If School is a setting where this service will be provided, please provide rationale, including the amount of time spent in school, and how this will be decreased over time.

If a residential setting is where services will be provided (e.g., shelter or group home) please provide rationale, including how this will be decreased over time.

Are any other family members in this household receiving CTA or other in-home services?

Please describe what changes or modifications have been attempted in regard to the current treatment plan or treatment interventions to address the youth's symptoms. Has the intensity or frequency of Outpatient services been modified prior to this request for CTA services? What was the youth's response to such changes?

Attachments: ☐ Individual Master Treatment Plan ☐ CTA Plan

Presenting Problems (specific behaviors, quotes, obstacles):

Precipitating/Proximal Factors:

Dangerousness (suicidal/homicidal ideation/Hx, Truancy, Elopement, etc.)**:**

Functional Impairments:

Support System:

Substance Use:

Psychiatric Medications:

Medical Issues:

Previous Treatment:

Plan to reduce CTA hours and phase out CTA services (discharge criteria, continued stay criteria)**:**

CTA CONTINUED STAY REQUEST

Progress in relation to specific symptoms:

Problems/Obstacles to Change:

Current Dangerousness (suicidal/homicidal ideation)**:**

Changes in Psychiatric Medications:

New Information:

Treatment Plan / Treatment Intervention Changes:

Plan for reduction of hours to phase out CTA services:

If CTA services are being requested beyond 90 days, statement from Supervising Practitioner regarding clinical justification for continued CTA:

MAGELLAN BEHAVIORAL HEALTH OF NEBRASKA
COMMUNITY TREATMENT AID (CTA) SERVICE PLAN

Child's Name: **Child's Medicaid Number:**

DATE	TARGET BEHAVIOR	TREATMENT INTERVENTION	INTERVENTION PARTICIPANT	EXPECTED OUTCOMES (describe outcome in concrete and measureable terms)	BASELINE MEASUREMENT:	PROGRESS TO DATE (noted in concrete and measureable terms)

CTA Signature/Credentials: _____ Therapist Signature/Credentials: _____