IOWA DEPARTMENT OF HUMAN SERVICES

REHABILITATIVE TREATMENT SERVICES AUTHORIZATION

Referral Worker:	DHS	JCS	Referral Worker Co.	Date of Authorization:	Effective Date:
CACT Member/ID/Signature				CACT Member/ID/Signature:	
CACT Member/ID/Signature				CACT Member/ID/Signature:	

CLIENT INFORMATION

Client Name				Billing County		State ID	Authorization #
Service Category	Factor	Factor	Factor	Factor	Factor	Diagnosis Code	Report Dated

REHABILITATIVE TREATMENT SERVICES AUTHORIZED

❑ Approved Rehabilitative	❑ Court Ordered	❑ Denied	❑ Appeal	❑ Exception

SCOPE	AMOUNT	DURATION
Family Centered	**Half-hour units**	**Months**
A1-xx: Therapy & Counseling		
A2-xx: Skill Development		
A3-xx: Psychosocial Evaluation		
Family-Preservation	**Units**	**Months**
B1-xx: Family Preservation	1	**2**
Treatment Family Foster Care	**Half-hour units**	**Months**
C1-xx: Therapy & Counseling		
C2-xx: Skill Development		
C3-xx: Behavorial Management		
Group Treatment - Required Services	**Day units**	**Months**
D1-xx: Community Residential Treatment		
D2-xx Comprehensive Residential Treatment		
D3-xx: Enhanced Residential Treatment		
D4-xx: Highly Structured Juvenile Program	123	6
Group Treatment: Optional/Additional Services	**Half-hour units**	**Months**
D5-xx: Therapy & Counseling for Child		
D6-xx: Therapy & Counseling for Family		
D7-xx: Family Skill Development		

❑ 'GGG' = Retroactive authorization
❑ 'MMM' = Modified with agreement
❑ 'RRR' = Modified without agreement
❑ 'EEE' = Immediate family-centered
❑

Comments: