Iowa Department of Human Services

REHABILITATIVE SERVICES AUTHORIZATION

Demographic Information

Date: May 20, 2003	Authorization number:	County of financial responsibility:
Referral worker: ☐ JCS ☐ DHS Name and title:		Telephone number:
Address: City, State, Zip		
Child's name:	Child's SID #:	Child's DOB:
Child's placement:	If other, please specify:	
Child's address:		
Child's parent name:	Parent's address:	
Child's parent name:	Parent's address:	

Requested Services

Scope	Amount	Duration	Scope	Amount	Duration

Assessments

Type (If other, specify)	Date	Source

DSM Diagnosis

AXIS I:	Date:
AXIS II:	
AXIS III:	Source:
AXIS IV:	
AXIS V:	

Medical-Behavioral Health Care Need

Child History: ☞

Risk factors:

Function or skill the child lost or never gained:

Interference in the normal maturation or learning process:

Individual dysfunction:

Relevant Family History: ☞

Risk factors:

Parental dysfunction resulting in detrimental effect on the child:

Strengths of the child, family, or environment:

Progress the child has made towards medical-behavioral needs:

Permanency goal: This goal is to achieve .

Expected service outcome:

Past and current services were reviewed: ☐ Yes ☐ No

The child has the capability to learn the function or skill: ☐ Yes ☐ No

AUTHORIZATION DETERMINATION

Risk Factors and Severity

Rehabilitative treatment services are necessary to remediate the following medical-behavioral needs of the child.

Primary factor:	Severity:
Secondary factor:	Severity:
Factor:	Severity:
Factor:	Severity:
Factor:	Severity:

Authorization

An adequate assessment has been made on which to base a determination regarding service necessity.
☐ Yes ☐ No If no, recommendation:

Authorization: ☐ Approved ☐ Denied ☐ Court Ordered ☐ Exception ☐ Appeal

Service category:

SERVICES

Scope	Amount	Effective Date	Final Day of Eligibility	Scope	Amount	Effective Date	Final Day of Eligibility

Authorization justification:

Identification of reasons if an authorization is different from what was recommended by the referral worker:

Signature:	Date:
Signature:	Date:
Signature:	Date:

IOWA DEPARTMENT OF HUMAN SERVICES

REFERRAL OF CLIENT FOR REHABILITATIVE TREATMENT AND SUPPORTIVE SERVICES

CLIENT INFORMATION (Provide information as it appears on FACS):

Child's Name	State ID #	Billing County #

To:

Referral Worker Name & Title
Telephone Number
Address
City, State, Zip

☐ REFERRAL: APPROVED, REHABILITATIVE NEEDS

☐ REFERRAL: APPROVED, NONREHABILITATIVE NEEDS

☐ REFERRAL: SUPPORTIVE SERVICES

☐ TERMINATION OF SERVICES

Service Code	Maximum Units	Maximum Duration	Date of Authorization	Authorization Number	Effective Date	Final Day of Eligibility

*You are authorized to provide the services listed above as of the dates listed and for the duration and intensity indicated. This notice supersedes any prior authorization of these same services as of the **EFFECTIVE** date indicated.*

Rehabilitative treatment services are necessary to remediate the following medical-behavioral needs of the child:

Child History:

Risk factors:

Function or skill the child lost or never gained:

Interference in the normal maturation or learning process:

Individual dysfunction:

Relevant Family History:

Risk factors:

Parental dysfunction resulting in detrimental effect on the child:

Strengths of the child, family, or environment:

Progress the child has made towards medical-behavioral needs:

Permanency goal: This goal is to achieve .

Expected service outcome:

Past and current services were reviewed:

The child has the capability to learn the function or skill:

Risk Factors and Severity:

Primary factor:	Severity:
Secondary factor:	Severity:
Factor:	Severity:
Factor:	Severity:
Factor:	Severity:

OTHER:

Referral Worker Signature	Date
Supervisor Signature	Date