Washington County Health and Human Services
Authorization Request Form

****This form is for use after **October 1, 2005*****

Type of Authorization:

☐ Initial Authorization		☐ Continued Treatment Authorization	
Provider Agency:		Location:	
Auth Start Date:		Auth End Date:	

Client Information:

Last Name:		First Name:	
DOB:		SSN#:	
Primary and Secondary Diagnoses:	I: II:	LOCUS/CASII Score: (if applicable)	

Funding: *(please complete all that apply)*

☐ OHP #:
☐ Medicare #:
☐ General Fund: *(must meet all the criteria listed below)* #:
- ☐ Washington County Resident
- ☐ Monthly Income: (income must be below 200% of poverty line)
- ☐ Number in Family:
- ☐ No insurance or is significantly underinsured (i.e. insurance benefit is exhausted or inadequate to provide the basic services needed to be successfully maintained)
- ☐ Has no current "prepaid" service authorization
- ☐ Cannot be adequately served by other community resources (i.e. free or low cost counseling or healthcare, primary care clinics, substance abuse treatment programs, etc.)

Authorization Type Requested: *(Please refer to the WaCo policy for service type criteria)*

OHP and General Fund:	OHP Only Auth Types:
☐ Outpatient Adult	☐ St. Mary's Home for Boys
☐ Rehab: Recovery Maint.*	☐ Janus Youth
☐ Rehab: Rehabilitation*	☐ Straight Ahead Shelter/Kerr
☐ Rehab: Intensive Comm.*	☐ MRDD
☐ Geriatric Outpatient	
☐ Geriatric Rehab	
☐ Child Level I Brief Treatment**	
☐ Child Level II Outpatient **	
☐ Child Level III Intensive**	
* *Requires LOCUS* ** *Requires CASII*	

All services must be pre-authorized. Attach a current treatment plan and assessment. Please complete LOCUS or CASII instrument if applicable and submit scoring sheet with request. Requests cannot be processed without required documentation. Please fax form and documentation to **503-846-4560**.

Clinical Supervisor Signature:_____ Date:_____

For internal use only:
Date received:_____ Date Processed:_____ PHTech reference #:_____