

Supported Employment and Peer Support Authorization Request



Check one of the following:

- Supported Employment Peer Support

***Required Information** – In order to ensure our members receive quality care, appropriate claims payment and notification of servicing providers, all required fields on this form must be completed. Please type or print in black ink and submit this request to the fax number above. For an urgent* request, do not fill out this form. Please call Ohana Health Plan at **1-866-401-7540**.

Member		
Ohana Member ID:	Today's Date:	
Member Full Name:	Assigned CBCM Agency:	
Member Phone Number:	Date of Birth:	
Home Address:		
Primary Contact and Relationship:	Primary Contact's Phone Number:	
Treating Case Management Provider		
Provider ID:		
Case Management Agency Providing Service:		
Phone Number:	Fax Number:	
Case Manager/Peer Supporter Name:		
Case Manager/Peer Supporter Phone Number:		
Diagnosis		
ICD-10 Diagnosis Code:	Description:	
ICD-10 Diagnosis Code:	Description:	
Medical Conditions:		
LOCUS Score/Acuity level:		
Service Requested		
Planned Dates of Service:		
HCPC Code	Description of Service	Visits/Frequency

(continued)

PRO_99879E Internal Approved 08172022

©Ohana Health Plan 2023

HI2PROWEB99879E_0000

Additional Requirements (Please complete corresponding checklist for the service requested)

<input type="checkbox"/> Supported Employment	<input type="checkbox"/> Peer Specialist
1. Compliant with BH CM Frequency of Contact <input type="checkbox"/> Yes <input type="checkbox"/> No 2. DVR/VA Recipient <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Transportation <input type="checkbox"/> Yes <input type="checkbox"/> No 4. I-9 Form with copies of required ID/Doc Resume <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Resume <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Individualized Treatment Plan specific to service requested <input type="checkbox"/> Yes <input type="checkbox"/> No	1. Compliant with BH CM Frequency of Contact <input type="checkbox"/> Yes <input type="checkbox"/> No 2. Participating in Wellness Recovery Action Planning (WRAP) <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Individualized Treatment Plan specific to service requested <input type="checkbox"/> Yes <input type="checkbox"/> No

Individualized Treatment Plan Specific to Service Requested

Member Last Name: _____ Member First Name: _____

Supported Employment Peer Support

Barriers	Possible Resolutions

Indicate the short-term goals and interventions relevant to the identified service:

Short-Term Goals	Start Date	Units Requested	Short-Term Interventions (Targeted to be completed within 3-month time frame)
1.			
2.			
3.			
4.			
5.			
6.			
Total Units Requested:			

Discharge Plan Summary (Identify possible resources/referrals for member post discharge):

1.
2.
3.