

Healthy Pathways Initial Request

**Authorization for Healthy Pathways will not be considered until
all sections of this form and assessment are completed.**

Member Information

Name (First, MI, Last):

SCHA ID Number:

Date of Birth:

Mailing Address:

Clinical Information

Service Start Date:

Primary DA Code(s):

Brief Summary of member's needs:

Case Manager Information

Case Manager Name:

Facility Name:

CM Phone Number:

CM Fax Number:

Facility Address:

Facility NPI:

Facility TIN:



Healthy Pathways Initial Assessment



***Important: Please enter the member's 8-digit PMI number clearly in the boxes below.
Please note that this form has been updated.**

1. Member PMI:

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Assessment

Response Definition: 1=Extremely Severe 2=Severe 3=Moderately Severe 4=Moderate 5=Mild 6=Very Mild 7=Impairment 8=NA

	1	2	3	4	5	6	7	8
2. Impairment of daily functioning due to mental health symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Member's need for engagement in mental health services.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Impairment of daily functioning due to substance use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Impairment of daily functioning due to lack of social support.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Member's impairment of functioning due to lacking financial, housing and/or transportation resources.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Referral to Healthy Pathways

7. Please select the most applicable single reason for referral.

- ☐ Does not meet MH-TCM DA Requirements
- ☐ Transitional Youth
- ☐ ER Use &/ or Hospital Frequency
- ☐ SUD Support
- ☐ Law Enforcement Contact
- ☐ Crisis Intervention
- ☐ Homelessness
- ☐ Connect with Providers
- ☐ Transitioning off MH-TCM
- ☐ Refer to clinician for DA
- ☐ Refer to MH professional for therapy
- ☐ Teaching skills to improve tenancy, manage money, complete paperwork and using transportation

If other, please briefly explain:

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Thank you for completing and returning the assessment!

