

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:		

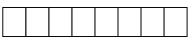
Case Manager Information		
Case Manager Name:	Facility Name:	
CM Phone Number:	CM Fax Number:	
Facility Address:		
Facility NPI:	Facility TIN:	

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:



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		
3. Member's need for engagement in mental health services.		
4. Impairment of daily functioning due to substance use.		
5. Impairment of daily functioning due to lack of social support.		
6. Member's impairment of functioning due to lacking financial, housing ar	nd/or	
transportation resources.		
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		
U 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 transport	rtation	
If other, please briefly explain:		

Thank you for completing and returning the assessment!