South Country HEALTH ALLIANCE

Fax Request to: 507-431-6329

Healthy Pathways
Renewal Request or End of Service Notification

☐ **Renewal Request** ☐ **Notification of End of Service**

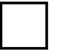
Authorization for Healthy Pathways will not be considered until all sections of this form and assessment are completed.

Member Information	
Name (First, MI, Last):	SCHA ID Number:
Date of Birth:	Address:

Clinical Information	
Service Start Date/Service End Date (DTR):	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 Assessment for Renewal or End of Services



***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:

2. Assessment Type:

☐ Renewal Request ☐ Notification of End of Service

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
3. Impairment of daily functioning due to mental health symptoms.	☐	☐	☐	☐	☐	☐	☐	☐
4. Member's need for engagement in mental health services.	☐	☐	☐	☐	☐	☐	☐	☐
5. Impairment of daily functioning due to substance use.	☐	☐	☐	☐	☐	☐	☐	☐
6. Impairment of daily functioning due to a lack of social support.	☐	☐	☐	☐	☐	☐	☐	☐
7. Member's impairment of functioning due to lacking financial, housing and/or transportation resources.	☐	☐	☐	☐	☐	☐	☐	☐

End of Service Only

8. Why is the Member ending services? (Please select one)

☐ Goals Met

☐ Member Transitioned to another service

☐ Member requested to discontinue with the program

☐ Unable to Reach (90 days)

If other, describe briefly:

9. If Member has transitioned to another service, please indicate which one.

☐ MH-TCM

☐ IRTS

☐ ARMHS

☐ SUD Treatment

☐ Out-Patient Treatment

☐ Waiver

☐ Housing Stabilization Services

If other, describe briefly:

Thank you for completing and returning the assessment