COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HIV AND STD PROGRAMS - CONTRACTED COMMUNITY SERVICES

MENTAL HEALTH SERVICES – TREATMENT EXTENSION REQUEST PROTOCOL

Treatment Extension Request Guidelines

Division of HIV and STD Programs (DHSP) will consider treatment extension requests for clients receiving Mental Health services under the following conditions:

- The client is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the proposed level of care is clinically necessary for the client to meet his/her treatment goals.

- The client is not yet making progress, but has the capacity to resolve his/her problems. S/he is actively working toward the goals articulated in the individualized treatment plan. Continued treatment at the proposed level of care is clinically necessary for the client to continue to work toward her/his treatment goals.

- New problem(s) have been identified that will be appropriately treated at the proposed level of care.

Treatment Extension Request Procedure

The contractor must submit the following documents to DHSP ***(All treatment records must be maintained in the client's file and made available to DHSP staff upon request).***

- A completed copy of Mental Health Services Treatment Extension Request form
- A copy of the current treatment plan
- A copy of the proposed revised treatment plan
- Copies of progress notes or other documents that support client's need for a treatment extension
- Agency letterhead requesting the treatment extension addressed to the Chief of Contracted Community Services:
  - Letter must be signed by your agency's executive director or designee
  - Request must be received by DHSP at a minimum of 30 days prior to additional sessions being provided to the client.

****Important Privacy and Security Guidelines for submitting Treatment Extension Requests****

All Treatment Extension Requests and accompanying document(s) MUST be submitted via secure facsimile to DHSP/Care Services Division Secure Fax Line: (213) 381-8022

- Please include fax cover letter indicating Agency name, Contract #, and Service Category.
- All documents containing Protected Health Information (PHI) must be transmitted in accordance with any applicable local, State and Federal laws and pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- Request(s) submitted via alternative method(s) will not be accepted.

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Treatment Extension Request Form

Client Information

Agency: _____ Client date of birth: _____ Casewatch ID#:_____

DSM Dx: _____ Date of last HIV Medical Visit: _____

Initial primary complaint/presenting problem: _____

_____

Extension Authorization Request

Initial treatment start date: _____ # sessions used to date: _____ Last psychotherapy session date: _____

Extension request start date: _____ # sessions requested: _____ Anticipated discharge date: _____

Previous Treatment Extension request(s) for this client? ---Select--- (If yes, please provide date(s):_____

Proposed treatment frequency: ---Select--- If other, please explain _____

Please provide details for the following below:

1. Reason(s) why current treatment plan is not adequate to address client's mental health needs.

2. Describe how additional session(s) will allow client to achieve treatment plan goals.

_____ _____ _____ _____

Requesting Clinician's Signature | Print Name/Date | Telephone #: | Email:

_____ _____ _____

Licensed Provider Signature | Print Name/Date | License #

DHSP Use Only

_____ _____ ☐Denied ☐Approved (# of Sessions) _____

DHSP Program Manager Signature | Print Name/Date

_____ _____ ☐Denied ☐Approved (# of Sessions) _____

Licensed Clinician's Signature | Print Name/Date

Reason for denial: _____

_____

_____

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