Psychiatric Partial Hospitalization
Intensity of Service Questions

Facility Name: ____
Name of Person Completing the Form: __________________________________
Title: ____
Date Completed: ____
Ages treated: _______________________
Is your facility accredited? YES☐ NO ☐
If yes, by which organization: ____

Is the facility licensed by the appropriate state agency?
YES☐ NO ☐
If yes, please provide state agency: _______________________________________
Please provide copy of licensure
If the answer is no, please explain with further detail:
____
____

Please review the Level of Care Utilization System (LOCUS) and Child and Adolescent Level of Care Utilization System (CALOCUS) documentation at the link below and attest that you meet the criteria as defined here.
LOCUS & CALOCUS Criteria

I attest that I've reviewed the LOCUS & CALOCUS Criteria for this level of service and meet the requirements as defined.
YES☐ NO ☐
If no, please explain:
____
____

Please provide copy of program description and relevant policies supporting the LOCUS & CALOCUS criteria and below requirements for this level of care.

1. Drug screens and relevant lab tests are completed and documented upon admission, as clinically indicated.
YES☐ NO ☐
If the answer is no, please explain with further detail:
____
____

2. Attending physicians are psychiatrists and are responsible for completing diagnostic evaluation within 48 hours of admission.
YES☐ NO ☐
If the answer is no, please explain with further detail:
____
____

3. The physician or physician extender provides ongoing evaluations with documentation as indicated by one of the following.
   At least 1 hour per month
   4 hours per month, at least weekly

   YES☐ NO ☐
   If you have additional information, please explain:
   ____
   ____

4. After a multidisciplinary assessment, an individualized treatment plan using evidence-based concepts, where applicable, is developed within five days of admission and amended as needed for changes in the individual's clinical condition.
   YES☐ NO ☐
   Please note: this plan should reference the following to develop treatment and discharge plans focused on the member:
   a. Precipitants to admission, including social determinants of health YES NO
   b. Family/other support systems available after discharge YES NO
   c. Community resources YES NO
   d. Need for supportive living placement to continue recovery YES NO
   e. Need for services for comorbid medical or psychiatric conditions YES NO

   If the answer is no, please explain with further detail:
   ____
   ____

5. Treatment programing includes and documents one individual counseling session weekly or more as clinically indicated.
   YES☐ NO ☐
   If the answer is no, please explain with further detail:
   ____
   ____

6. The members receive daily treatment by a licensed behavioral health practitioner.
   YES☐ NO ☐
   If the answer is no, please explain with further detail:
   ____
   ____

7. Licensed behavioral health practitioners supervise all treatment.
   YES☐ NO ☐
   If the answer is no, please explain with further detail:
   ____
   ____

8. Mental Health and Medical services are available 24 hours per day, seven days per week, either on-site, via telehealth, or off-site by arrangement.
   YES☐ NO ☐
   Please cite relative policy reference supporting the above, and if the answer is no, please explain with further detail:

   ____
   ____

9. Your program is a multidisciplinary treatment program that occurs five days a week and provides weekly clinical services to comprehensively address the needs identified in the member's treatment plan.
   Note: *The intent of the standard for weekly treatment program (groups, activities, and psychotherapies) is that they are evidenced based and are explicitly focused on the alleviation of the current condition as opposed to providing general recreation activities, watching videos, etc. and other facility offerings that are not tied back directly to the treatment plan.*
   YES☐ NO ☐
   If the answer is no, please explain with further detail:
   ____
   ____
   Please indicate the hours per week of
   a. Non-psychiatric clinical services ______ hours/week
   b. Support services ______ hours/week

10. For Members receiving boarding services, during non-program hours the member is supported in and allowed the opportunity to function independently and develop and practice new recovery skills in the real world to prepare for community re-integration and sustained, community-based recovery.
    YES☐ NO ☐ N/A ☐
    If the answer is no, please explain with further detail:
    ____
    ____

11. Safety plan including access for the member and/or family/support system to professional supports outside of program hours are made and documented.
    YES☐ NO ☐
    If the answer is no, please explain with further detail:
    ____
    ____

12. Recent treating providers are contacted by members of the treatment team to assist in the development and implementation of the initial individualized treatment plan within 5 days of admission.
    YES☐ NO ☐
    If the answer is no, please explain with further detail:
    ____
    ____

13. Family participation:

a. Family treatment is provided at an appropriate frequency. If Family treatment is not rendered, the facility/provider specifically lists the contraindications to Family Therapy.

YES☐ NO ☐ N/A ☐

If the answer is no, please explain with further detail:

____

____

b. For children/adolescents: The family/support system assessment is completed with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur as clinically indicated.

YES☐ NO ☐ N/A ☐

If the answer is no, please explain with further detail:

____

____

c. For children/adolescents: The family/support system assessment is completed within 5 days of admission with the expectation that family is involved in treatment decisions and discharge planning throughout the course of care. Family sessions will occur at least weekly or more often if clinically indicated.

YES☐ NO ☐ N/A ☐

If the answer is no, please explain with further detail:

____

____

d. Family participation is conducted via telephonic sessions when there is a significant geographic or other limitation.

YES☐ NO ☐

If the answer is no, please explain with further detail:

____

____