Please submit to:
RISE
1334 Dewey Court
Madison, WI 53703
Attn: Prior Authorization
or
E-mail to: pa@risewisconsin.org
Fax to: 608-250-6637
or
For all ARTT CCF enrollees:
Fax to: 608-288-2405

Children Come First - RISE
Prior Authorization/Progress Report

(Prior authorization, not to exceed 3 months, must be received prior to service being authorized and to be used for the following CCF service types: Individual Therapy, Individual AODA Therapy, Family Therapy, Group Therapy, Group AODA Therapy, Special Therapy, Specialized Offender Treatment, In-Home Treatment, Family Preservation, Day Treatment, Day Treatment-AODA, Transitional Day Treatment,

Check One: ☐ **Initial PA Request (date range requested, 1-3 months) :**				☐ **Reauthorization (date range requested, 1-3 months):**	
Provider/Agency Name:				**CCF Service Type Requested (see above):**	
Client Name:		**Date of Birth:**		**Units Requesting:**	☐**Week** ☐**Month**
CCF Coordinator:		**Date of last communication with coordinator:**			
Are there barriers preventing progress toward goals (ex. missed appointments, transportation, etc.)?:					

Therapy Goal(s) for this authorization period (please check how long this goal has been addressed in therapy)	**Intervention** Treatment Modality (Individual, family, group, insight, play, experiential, etc.)	**Progress (list progress for reauthorization request only)** (please include observable strengths during this authorization period and how cultural considerations are being incorporated into the treatment process) **Please use the back of this form if more space is needed**
1. ☐ 0-3 months ☐ 3-6 months ☐ 6-12 months ☐ over 12 months		
2. ☐ 0-3 months ☐ 3-6 months ☐ 6-12 months ☐ over 12 months		
3. ☐ 0-3 months ☐ 3-6 months ☐ 6-12 months ☐ over 12 months		
Provider Signature or Typed Name:		Date:

For office use only:
☐ PA/PR approved for the following time period ____ ☐ PA/PR denied due to ____

	Additional Progress (please include observable strengths during this authorization period and how cultural considerations are being incorporated into the treatment process**)** **Please use the back of this form if more space is needed**
Goal 1	
Goal 2	
Goal 3	