**Children Come First - RISE**

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

**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.)?:**  |       |

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| --- | --- | --- |
| **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 |
| 1.
 |       |       |
| [ ]  0-3 months [ ]  3-6 months[ ]  6-12 months [ ]  over 12 months |
| 1.
 |       |       |
| [ ]  0-3 months [ ]  3-6 months[ ]  6-12 months [ ]  over 12 months |
| Provider Signature or Typed Name:       | Date:       |

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| **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** |       |

 Rev. 7/2020