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| **Person Served Name:** | | **Avatar ID Number:** |
| **Admission Date:** Enter Admission Date | **Previous Continued Services Justification(s):** Enter Date(s) | |

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| ***Counselor or LPHA Recommendation:*** | | |
| **Counselor or LPHA must make a recommendation:**  After reviewing the person served progress and eligibility to continue receiving treatment services:    1. \_\_\_\_\_\_ I ***do*** recommend that the person served continue treatment services.  2. \_\_\_\_\_\_ I ***do not*** recommend that the person served continue treatment services. | | |
| **Counselor/LPHA Name Printed, Title:** | **Counselor/LPHA Signature:** | **Date:** |

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| ***Medical Director or LPHA Determination of Medical Necessity:*** |
| **Medical Director or LPHA Must Initial Either 1 or 2:**   1. **\_\_\_\_\_\_\_\_\_** After review of treatment records (the person served personal, medical and substance use history, documentation of the most recent physical examination, progress notes and treatment plan goals, the LPHA or Counselor’s recommendation and the person served prognosis), I have determined that continuing treatment **is** medically necessary and the person served should continue treatment. |
| **2. \_\_\_\_\_\_\_\_\_** After review of treatment records (the person served personal, medical and substance use history, documentation of the most recent physical examination, progress notes and treatment plan goals, the LPHA or Counselor’s recommendation and the person served prognosis), I have determined that continuing treatment **is not** medically necessary and the person served should be discharged from treatment.  **If it is determined that continuing treatment service is not medically necessary, the provider shall discharge the person served from the current level of care and transfer to the appropriate services along with issuing a Discharge/LOC Transition NOABD.** |

***Narrative Justification:* Medical Director or LPHA must articulate why continued treatment is medically necessary.**

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| Enter narrative |

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| **LPHA/Medical Director Name Printed, Title:** | **LPHA/Medical Director Signature:** | **Date:** |