

Initial Hospitalization Authorization Form for Youth (under age 18 year) Form must be faxed to MHRB: (513) 695-1776 Questions? Call Amanda Peterson, Deputy Director at 513-695-1695 ************************************ Date: _____ Location of Crisis Service: ____ Patient's name: _____ Address: DOB: _____ Name and Contact information of Parent/Guardian: ______ Is the patient uninsured? Yes No Has the patient been receiving outpatient behavioral health services? No If yes, the last date services were received: Name of agency, case manager and psychiatrist: Reason for admission to hospital? (include dates, identifying data, pertinent past history - med, psych & CD): Current condition/MSE:



DSM-5 Diagnosis(es):		
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Name of Hospital:		
Name of Hospital or Crisis Staff:	Signature :	
Email Address:	Phone #:	
*Documentation can be sent as attac	chments as well	
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FOR COMPLETION BY HOSPITAL:		
Date patient will see a financial counselor?		
Though uninsured, does client qualify	y for hospital assistance/and or Medicaid? Yes No	
If yes, at what percentage of coverag	e?	
Per Diem Cost:		
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FOR COMPLETION BY MHRB:		
*Admission Date:	_ *Approved through date: Denied ()	
Recommended alternative level of care (if denied):		
Other comments/notes:		
Name of MHRB Staff:	Signature :	