### ICMS Clinical Justification Form for Units in Excess of the Monthly limit

*For ICMS providers who anticipate a specific consumer will require service delivery in excess of the monthly limit of 50 units per consumer as established in the New Jersey Application for Payment Processing (NJMHAPP), this form* ***must be*** *completed and submitted by ticket to the DMHAS – Mental Health FFS Unit for review* ***by the 15th day of the month after the services were delivered****. The MH-FFS Unit will then forward the completed document to the appropriate DMHAS Program Analyst, Regional Coordinator and/or DMHAS Statewide ICMS Coordinator for review.*

COUNTY:       AGENCY:       DATE:

CONSUMER NAME:       DATE OF BIRTH:

NJMHAPP ID#       DATE OF ADMISSION TO ICMS:

MONTH ICMS SERVICES WILL EXCEED THE MONTHLY LIMIT:

NUMBER OF UNITS THAT WILL EXCEED THE MONTHLY LIMIT:

DATE OF DISCHARGE FROM INPATIENT FACILITY IF D/C OCCURRED WITHIN LAST 60 DAYS:

NAME OF FACILITY CONSUMER DISCHARGED FROM (IF APPLICABLE):

PLEASE PROVIDE THE CONSUMER’S CURRENT RISK LEVEL BASED UPON ASSESSED RISK OF HOSPITALIZATION:

CLINICAL JUSTIFICATION FOR ICMS UNITS FOR ENTIRE MONTH -- **PLEASE INCLUDE AND/OR ATTACH ACTUAL PROGRESS NOTE DOCUMENTATION DETAILING: DATES OF CONTACT FOR MONTH, # OF UNITS PER CONTACT, SERVICES PROVIDED**

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| **DATE** | **# units** | **Detailed description of activity/time spent with consumer** |
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**~ Submit completed form via NJMHAPP ticket and select “ICMS Limit Request” in dropdown menu ~**

**AGENCY REPRESENTATIVE SIGNATURE:**

*DMHAS USE:*

**ICMS Units Exceeding the Monthly Limit/STATE RATE REIMBURSEMENT:**

[ ]  **Approved (\_\_ units)**  [ ]  **Denied (\_\_units)** [ ]  **Additional Information Needed**

DMHAS FFS Representative: DATE: Click here to enter a date.

 DMHAS Program Analyst: DATE: Click here to enter a date.

 DMHAS ICMS Coordinator: DATE: Click here to enter a date.

DMHAS staff comments: