Name: ID#: SAR #: SAR Submit Date:
DOB:

State- Funded Services
Respite – Hourly – Individual (Child Only) - YP010
Initial Review Criteria

Met	Not Met	N/A	Required Elements to Approve Service
☐	☐	☐	The service includes non-treatment, non-habilitation support services provided to a child in order to provide temporary or occasional relief for regular caregivers/ family or family substitute AND
☐	☐	☐	The service is provided face-to-face providing care to the child and may include time spent transporting the child to or from services.
☐	☐	☐	The service provider addresses the health, nutrition, and daily living needs of the child.
☐	☐	☐	The service may be provided in the child's own home or other location that is not subject to licensure.
☐	☐	☐	The service may be requested up to 32 units per day, 384 units per year maximum per Partners BHM Benefit Plan and is within the current treatment plan.

Respite – Hourly – Individual (Child Only) - YP010
Continued Service Criteria

Met	Not Met	N/A	Required Elements to Approve Service
☐	☐	☐	The service may be requested up to 32 units per day, 384 units per year maximum per Partners BHM Benefit Plan and is within the current treatment plan.
☐	☐	☐	The family or family substitute continues to need temporary relief from caregiving responsibilities.
			Service Maintenance Criteria
☐	☐	☐	The service may continue as long as the family continues to need periodic relief from the responsibility to provide care for the recipient.

Respite – Hourly – Individual (Child Only) - YP010
Discharge Criteria

Met	Not Met	N/A	Required Elements to Approve Request
☐	☐	☐	N/A

Initial Review:

All Criteria Met: ☐ YES – APPROVE ☐ NO Review with Clinical Reviewer

Comments:

Care Manager Name, Credentials: Date:

Clinical Review:

Name: ID#: SAR #: SAR Submit Date:
DOB:

☐ Approved ☐ Send to Peer Review

Comments:

Reviewer Name, Credentials: Date: