|  |
| --- |
| Placement Authorization Request Form |
|  |
|       |  |       |  |       |  |       |
| Client Name (AKA if known) |  | SSN |  | DOB |  | BIS Number (if available) |
|  |
| Client’s current locations |       | Provider RU# (if known) |       |
|  |
| Is Client a SF resident? | [ ]  Yes [ ]  No | Where was client last 30 days? |       |
|  |
| Entitlements: | [ ]  Medi-Cal | [ ]  Medicare | [ ]  SSI | Other Income Source: |       |
|  |
| Conservator Status: | [ ]  T-Con | [ ]  Permanent LPS | [ ]  Probate | Conservator Name: |       |
|  |
| Client can effectively manage ADLs without restrictions | [ ]  Yes [ ]  No |  | If incontinent, can client effectively manage self-care? | [ ]  Yes [ ]  No |
|  |
| SPR CLIENT: | [ ]  Yes [ ]  No [ ]  Pending | PLEASE NOTE, IF SPR CLIENT, APPROVAL IS REQUIRED |
|  |
|       |  |       |  |  |
| SPR Clinician |  | Telephone # |  |  |
|  |
| HAS ICM: | [ ]  Yes | [ ]  No | [ ]  Pending |       |  |       |
|  | ICM Clinician |  | Telephone # |
| Level of Care Requested: |       | DSM V Diagnosis Code(s) |       |
|  |
| Clinical Indications for Level of Care Request This area will expand as you type |
|  |
| Recommended Treatment Goals This area will expand as you type |
|  |
| Submitted By:  |       | Date: |       |  |
|  |
| Telephone #: |       |  | Fax #:  |       |  |
|  |
|  |
| PLACEMENT RECOMMEDATIONS | [ ]  **PLACEMENT AUTHORIZED** | [ ]  Med Supported Detox |
|  |
| [ ]  AOD DDx Res | [ ]  MH DDx Res | [ ]  Transitional Res | [ ]  LSAT | [ ]  Clay/Loso | [ ]  Our House | [ ]  RCF/E |
|  |
| [ ]  AOD Social Model Detox | [ ]  AOD Social Model Res | [ ]  Co-Op | [ ]  Support Service Hotel | [ ]  Hotel | [ ]  DAH |
|  |
| **SPECIFY** This area will expand as you type |
|  |
| [ ]  **NOT AUTHORIZED** REASON: This area will expand as you type |
|  |
| Authorizing Clinician (print name) |       | Date |       |  |
|  |