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