REQUEST FOR CONCURRENT SERVICE REVIEW (RCR)
SUBMIT TO MENTAL HEALTH PLAN TO:
Authorization Services
Alameda County Behavioral Health Care Services
2000 Embarcadero Cove, Suite 400
Oakland, CA 94606
Phone (510) 567-8141 Fax (510) 567-8148

Client Name: _____
Client DOB: _____
Client CIN or SSN: _____
Provider Name: _____
Agency, if applicable: _____

CLIENT PLAN UPDATE

Complete in collaboration with client whenever possible.

General Instructions: Respond legibly to all questions; indicate "N/A" or "none" if question is not relevant. Incomplete or illegible forms will be returned to sender. ***Clinician & client signatures are required****. Online Completion is sufficient; Submit extra page, if needed, and check this box* ☐ *. For HPAC: Required at 6 months of if continuing services.*

1. **Progress toward mental health objectives since last authorization** *(If little or no progress, indicate why):*
   _____
   _____
2. **Indicate the current specific problems in daily functioning & clinical risks that mental health services will address** (e.g., *"Symptoms continue to meet criteria for depressive disorder and prevent client from reaching goals to become more social, complete work tasks & parent effectively."If risks are identified they must be specifically addressed):*
   _____
3. **Next 6-month specific mental health objectives (observable or measurable) to support improved functioning:**
   _____
4. **Changes in treatment, medication and/or diagnosis since last authorization:**
   _____
5. **If applicable, please respond to questions from last Authorization Reviewer here**:
   _____
6. **Service Request for Authorization** *Please use one line for each service. (NOT REQUIRED FOR HPAC)*

CPT Service Code (per your rate sheet) Ex: x9502	**Service Description** (per your rate sheet) Ex. Individual Therapy	**Frequency of Service** **Ex.** 1x/week	**Diagnosis Code(s) Addressed** **Ex.** 296.22

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7. Change in Special Needs? _____
8. Updated Strengths and Resources _____
9. If closing case, date of last session: _____ Referrals made: _____

***CLIENT'S SIGNATURE:_____ Date_____**
Legal Representative's signature., if required:_____ Date_____
Specify Legal Rep.'s Relationship (e.g., parent, guardian, conservator): _____
If client/legal rep. verbally agreed with Client Plan but declined to sign, provide the Date: _____
If client/legal rep. disagrees with Plan, provide Reason/Date: _____
Client's signature required above AND client must be offered copy of Client Plan page unless clinician believes client's condition would suffer. If so, provide Reason/Date:_____

Provider/Clinician information is required on the line below.

_____

Clinician's printed name **Signature with discipline (e.g., MFT, LCSW, MD)** **Date**

If Clinician is not licensed, Licensed Supervisor's information is required on the line below:

_____

Lic. Supervisor's printed name **Signature with discipline (e.g., MFT, LCSW, MD)** **Date**

PRINT RESET EMAIL