Children's Placement Authorization for Alameda County BHCS

Client Information

Name:_______________ DOB:_______________

PSP#:_______________ SSN:_______________

Provider: _______________ **Admission Date:** _______________

Placed through: ☐ AB3632 ☐ Other School Placements ☐ Social Services ☐ Juvenile Probation ☐ Project Destiny

Completed by:_______________ **Date:** ________ **FAX:**_______________

Return to (if different from above) Contact Person:_______________ **FAX:**_______________

AB3632 Status: Yes ☐ **IEP Date :**________ **No** ☐ **Explain**_______________ **Short-Doyle** ☐

Service:	**Day Treatment:**	**Residential Treatment with Day Treatment**
	Rehabilitative Full ☐ Rehabilitative Half ☐ Intensive Full ☐ Intensive Half ☐	Rehabilitative Full ☐ Rehabilitative Half ☐ Intensive Full ☐ Intensive Half ☐ 5 days ☐ 5 days+ ☐

Initial Authorization

Yes ☐ No ☐	Start Date:	End Date: Intensive 90 days ☐ Date: Rehabilitative 180 days ☐ Date:

Signature:_______________ **Date:** _______________
Chief of Children's Specialized Services or AB 3632 Coordinator (FAX 510 763-2647)
or
Signature:_______________ **Date:** _______________
RCL 13/14 Coordinator (FAX 510 763-2647)
or
Signature:_______________ **Date:** _______________
ECMH Coordinator (FAX 510 383-1760)
or
Signature:_______________ **Date:** _______________
Chief of Outpatient Services (FAX 510 481-3770)

Medi-Cal Status: **If Yes, Medi-Cal #:**_______________ **If No, Check one:** ☐ Medi-Cal Application was made on: ________ ☐ Not required to apply (see comment section) ☐ Facility will assist client with Medi-Cal Application ☐ Other insurance (explain in comment section) **Comments:**_______________	**PST Review only** ☐ Medi-Cal current ☐ Medi-Cal lapsed (see comment section) ☐ Pursue Healthy Families **Comments:**_______________ **PST Signature:**________ **Date:**________

CC: Program ☐ **(by fax)** **QA Office** ☐ **(QIC 22711)** **PST Office** ☐ **(QIC 22706)** **chart** ☐

Distributed by_______________ Date_______________

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