PLACEMENT AUTHORIZATION FORM COMPLETION INSTRUCTIONS

- Prior to routing the form to the BHCS staff who will be doing the initial authorization, completely fill out the top half of the form (highlighted section on the example). The client's social security number is very important for verifying insurance coverage.

- Proceed to the Medi-Cal Status portion of the form and fill out the highlighted section. If the program is unable to assist the client with the application for Medi-Cal or needs additional training, contact the Benefits Management Office at Alameda County Behavioral Health Care Services at (510) 383-1566.

Incomplete forms will be returned and may result in a delay of the Placement Authorization for Day Treatment.

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:	**PST Review only**
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:**_____	☐ 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_____

CONFIDENTIAL