



Children's Placement Authorization for Alameda County BHCS

Client Information

Name: _____ DOB: _____

PSP#: _____ SSN: _____

Residential Care Level (if applicable) RCL 12 RCL 13/14 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 <input type="checkbox"/>	Rehabilitative Full <input type="checkbox"/>
	Rehabilitative Half <input type="checkbox"/>	Rehabilitative Half <input type="checkbox"/>
	Intensive Full <input type="checkbox"/>	Intensive Full <input type="checkbox"/>
	Intensive Half <input type="checkbox"/>	Intensive Half <input type="checkbox"/>
		5 days+ <input type="checkbox"/>

Initial Authorization

Yes <input type="checkbox"/>	Start Date:	End Date:
No <input type="checkbox"/>		Intensive 90 days <input type="checkbox"/> Date: _____
		Rehabilitative 180 days <input type="checkbox"/> 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)

<p>Medi-Cal Status: If Yes, Medi-Cal #: _____ If No, Check one: <input type="checkbox"/> Medi-Cal Application was made on: _____ <input type="checkbox"/> Not required to apply (see comment section) <input type="checkbox"/> Facility will assist client with Medi-Cal Application <input type="checkbox"/> Other insurance (explain in comment section) Comments: _____</p>	<p>PST Review only <input type="checkbox"/> Medi-Cal current <input type="checkbox"/> Medi-Cal lapsed (see comment section) <input type="checkbox"/> Pursue Healthy Families Comments: _____ PST Signature: _____ Date: _____</p>
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CC: Program QA Office PST Office chart (by fax)
(QIC 22711) (QIC 22706)

Distributed by _____ Date _____