Behavioral Health Department
Alameda County Health

Utilization Management
2000 Embarcadero Cove, Suite 400
Oakland, Ca 94606
510-567-8141

Specialty Mental Health Services (SMHS) ART Residential Treatment Service Authorization Request (SAR)

To Be Completed by Provider Requesting Adult Residential Treatment Authorization
SEND THIS FORM TO either: utilizationmanagement@acgov.org OR FAX (888) 860-8068
Please ensure that the program enrollment has been entered into SmartCare

PROGRAM INFORMATION			
Program Name:			
PROVIDER INFORMATION			
Staff Point of Contact:	Phone #:	Email:	Fax:
CLIENT INFORMATION			
Client Name:	DOB:	Age:	
Client SmartCare#:	Medi-Cal: ☐Yes ☐No	Alameda County Resident? ☐Yes ☐No	
Private or Other Health Insurance:			
SERVICE AUTHORIZATION REQUEST			
☐ Initial	If Initial, include admission date here:		
☐ Continuation	If Continuation, include expiration date of current authorization here:		
☐ Break in Service	If Break in Service, provide dates here:		
Additional Comments and/or Reason for Break in Service:			

IF THIS IS AN INITIAL AUTHORIZATION REQUEST (FIRST TIME REQUESTING AUTHORIZATION FOR THIS EPISODE), PLEASE **STOP** HERE.

THE REMAINDER OF THIS FORM IS FOR CONTINUATION AUTHORIZATIONS ONLY.

Please send this form five business days before the expiration of the current authorization.

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MENTAL HEALTH & SUBSTANCE USE SERVICES

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Please answer the questions below to support your request for authorization:

Is there at least one progress note submitted for each billable day that describes the mental health services that were provided? ☐ Yes ☐ No (if no, please correct this problem and then submit the SAR)
Please describe how this person continues to benefit from your program:
What coping and life skills does the client need to develop to be able to successfully discharge to a lower level of care? How is the program addressing these needs?
What community resources/supports does the client need to connect with to be able to successfully discharge to a lower level of care? How is the program supporting the client in obtaining/connecting with these resources and supports?
What specific indicators will demonstrate that this person is ready to transition to a lower level of care in the future?
Please describe the current discharge plan that the treatment team has made with this individual including plans for continued treatment, housing and other supports to maintain wellness:
If the individual has a Substance Use Disorder, have they been referred to CenterPoint for SUD treatment? If yes, describe engagement in SUD treatment. If not, please explain why. Please describe the Stage of Change they are in and how the program is supporting them in moving forward in their substance use recovery.
When is the anticipated date for discharge to a lower level of care? ☐Within 30 days? ☐ Beyond 30 days? Date:

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ANTICIPATED REFERRALS:

☐ Community Support Group	☐ Legal/Criminal Justice	☐ Housing/Shelter
☐ Primary Care/Medical	☐ Dental	☐ Job Skills/Employment/Volunteering
☐ Education	☐ Benefits (GA, SSI/SSDI, etc)	☐ Other Social Services (211)
☐ Mental Health referral (ACCESS)	☐ SUD	☐ Other: _____