Behavioral Health Department
Alameda County Health

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

SMHS RESIDENTIAL TREATMENT TYPE			
☐ Adult Residential Treatment (ART) Choose an item			
☐ Crisis Residential Treatment (CRT) Choose an item			
PROVIDER INFORMATION			
Referring Clinician Name:	Contact #:	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 Click or tap to enter a date.		
☐ Break in Service	If Break in Service, provide dates here: From to		
Additional Comments:			

Print Name _____ Signature _____ Date