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|  |  | 2000 Embarcadero Cove, Suite 400  Oakland, Ca 94606  510-567-8100 / TTY 510-533-5018  Karyn L. Tribble, PsyD, LCSW |

**Specialty Mental Health Services (SMHS) Residential Treatment**

**Service Authorization Request (SAR)**

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| **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 InSyst# (PSP): | | | Medi-Cal: Yes No | | Alameda County Resident?  Yes No | |
| Private or Other Health Insurance: | | | | | | |
| **SERVICE AUTHORIZATION REQUEST** | | | | | | |
| Initial | If Initial, include admission date here: Click or tap to enter a date. | | | | | |
| 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 6/24/2021 to 7/3/2021 | | | | | |
| Additional Comments: | | | | | | |

Click or tap here to enter text. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Click or tap here to enter text.

Print Name Signature Date