Santa Clara Valley Health & Hospital Systems Department of Alcohol and Drug Services

Adult System of Care
QI Authorization

Client Name: ______________________ **Date Received:** ______________

UNI/Care #: ______________________

Requesting Counselor: ______________________ **Phone #:** ______________

Transfer From:			Transfer To:	
☐ AARS	☐ FCS Julian		☐ CADS	
☐ AMT CVC	☐ FCS 1st St.		☐ Parisi HOTH	☐ Res Wait List
☐ AMT AHC	☐ FCS PA		☐ Horizon South	
☐ AMT S. Co.	☐ IHC		☐ PWAY MPL	☐ Res via Detox
☐ Central	☐ Proyecto		☐ PWAY House	
☐ YSOC/TAY	☐ PSAP		☐ P90 3rd. St.	
☐ CDCR	☐ PWAY OP		☐ P90 9th St.	
☐ DD Case Manager	☐ Medical Homes			

☒ ASOC ☐ AB109 ☐ AB109 CASU ☐ CDCR

Comments/Rationale for increase LOC/specific provider (include applicable ASAM Dimensions):

Dim. 1 - __
Dim. 2 - __
Dim. 3 - __
Dim. 4 - __ SOC
Dim. 5 - __ I
Dim. 6 - __
APPROVED: ☐ **YES** ☐ **NO** **Reason for Denial:**
Recommendation if denied:

QI Name:	QIC Name	**QI Signature:**		**Date:**	

Confidential Patient Information Statement

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