SCVHHS Department of Alcohol & Drug Services System

Authorization for Residential Extension of TX

Date: Click here to enter a date.

Agency: ______ **Counselor's Name:** ______ Phone: ______

Client Name: ______ **Unicare:** ______

Date Entered TX: Click here to enter a date. **# of Additional Days Requested:** ______

If Prior Extension, date of Last Auth: Click here to enter a date. **# of days Authorized:**

Anticipated Discharge Plan: ☐ **Outpatient** ☐ **IOP** ☐ **THU**

Additional Discharge Plan Details:

Current TX Plan: # of Action Steps assigned: ______ **# of Action Steps completed to date:** ______

Brief summary of AOD-related clinical issues on TX Plan that require continued stabilization in residential. List specific dimensions, progress made and remaining problem areas. Specify actions to be taken for each dimension:

Dim ______ **SOC:** ______

Dim ______ **SOC:** ______

Dim ______ **SOC:** ______

Counselor Sig: **Date:** **Clinical Sup Sig:** **Date:**

For QI Admin Staff only:

Approved: YES ☐ **NO** ☐ **Date From:** ______ **Date To:** ______

If Denied, List Reasons:

If Denied, List Recommendations:

QI Signature: ______ **Date:** ______

Confidential Patient Information Statement

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