# 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: ________________________

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**Confidential Patient Information Statement**

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9/17/15pc