YOLO COUNTY ALCOHOL, DRUG & MENTAL HEALTH DEPARTMENT

SERVICE AUTHORIZATION REQUEST FORM

☐ Initial ☐ Annual ☐ Reauthorization ☐ Adult ☐ Children

Client Name: **MR #:** **Auth #:**

Last, First, MI

Social Security Number: **Date of Birth:**

Address: **Phone #:**

City: **State:** **Zip Code:**

Provider:

Funding Source (Check One):

☐ Medi-Cal ☐ Medi-Cal/EPSDT (Under 22 years of age)

☐ Medicare/Medi-Cal ☐ Other (Specify): _____

DSM Diagnosis:

Axis I: (primary) _____

Axis I: _____

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Requested Services: _____ **to** _____

AUTHORIZED SESSIONS

_____	1530 A/B	Assessment	_____	1501	Case Management/Brokerage
_____	1532 A/B	Reassessment	_____	1502	Discharge Planning
_____	1534 A/B	Individual Therapy	_____	1510 A/B	Collateral
_____	1536 A/B	Group Therapy	_____	1540	Rehabilitation/ADLs
_____	1538	Plan Development	_____	1542	Group Rehabiliation/ADLs
			_____	1570	Crisis Intervention
_____	1095	Day Rehab. (Full Day)	_____	1558	TBS Services
_____	1091	Day Rehab. (Half Day)			
_____	1085	Day Treatment Int. (Full Day)	_____	1560	Medication Support-MD/DO/NP/PA
_____	1081	Day Treatment Int. (Half Day)	_____	1561	Medication Support-RN
			_____	1562	Medication Support-LVN/LPT

PLEASE NOTE:

1. If the client is a Medi-Cal beneficiary, payment for the services described in this certification are subject to the Medi-Cal beneficiary's eleigibility at the time the services are provided.
2. Reauthorization requests are due **10 working days** before the expiration date on this authorization.

Primary Clinician: _____ **Date:** _____

Supervisor: _____ **Date:** _____

(If Primary Clinician is Unlicensed)

Yolo County ADMH Use Only

Authorized Service Date Range: _____ **to** _____

Authorized By: _____ **Date:** _____

Client's Name: _____ **MR #:** _____

Revised 6/19/2012

This form supersedes all other versions.