



COUNTY OF SAN MATEO
HEALTH SYSTEM

BEHAVIORAL HEALTH & RECOVERY SERVICES
TREATMENT EXTENSION REQUEST

*This request is for clients who may need treatment stays in excess of 90 days
Only one extension exceeding 90 days may be authorized per 12 month period
Up to 30 days may be requested*

Program: _____ **Level of Care:** _____

Client Name: _____ **Admit Date:** _____

Date of Birth: _____ **Avatar ID:** _____

What Treatment Goals have not been met?

What will be achieved in this extension?

Counselor Name: _____ **Phone:** _____

Counselor Signature: _____ **Date:** _____

Client Signature: _____ **Date:** _____

- Attach Current Treatment Plan and 60 Day Plan**
- Email Form to: GRP_HS_BHRS_RTXTEAM@smcgov.onmicrosoft.com or Fax: 650.802.6440**

Extension Approved: Yes No

Extension NOT Approved Due to:

- Not eligible for Extension: Benefit utilized in past 12 month period
- Insufficient / Incomplete information
- Treatment Goals / Interventions need clarification
- Other: _____

RTX Member: _____ **Date:** _____