SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Send to
HS_BHRS_AdultUM@smcgov.org
FAX (650) 522-9830

Adult Residential Authorization Form

Name:	DOB:	MH#:	Diagnosis:

Service Type/Program

	Residential Program		Crisis Residential		Inpatient Eating Disorder
☐	CAMINAR EUCALYPTUS HOUSE 412900	☐	SERENITY HOUSE CRISIS RES 41E400	☐	ALTA BATES SUMMIT MCAL CNTR-HC 41ET01
☐	CAMINAR HAWTHORNE HOUSE 415600	☐	CRESTWOOD PONDEROSA HOUSE MHRC 414201	☐	TELECARE SAGE HOUSE MHRC 414801
☐	MATEO LODGE WALLY'S 419900	☐	STARS ACACIA HOUSE MHRC 414500	☐	CAMINAR WILLOW HOUSE MHRC 414301
☐	SUNOL HILLS 413000	☐		☐	

Authorization Request for Residential Services (completed by Residential Provider)

Admission Date _____ # Days Requested _____

Period Requested: Start Date _____ End Date _____

Type of Request: ____Initial Request ____Re-authorization Request (continued stay)

**Subsequent requests must be accompanied by Progress Summary, and revised Treatment Plan (if applicable)*

_____ _____ _____
Requesting Staff Name | Date of Request | Contact Information

To Be Completed by San Mateo County Adult UM Team

Approval for Residential Services

Request Receipt Date_____

Service Type: ☐ Adult Residential ☐Adult Residential Locked ☐Crisis Residential ☐Inpatient Eating Disorder

☐ Residential services are approved for # days _____

Start Date _____ End Date _____

☐ Residential Services not approved, NOA required Explanation
☐ Residential Services already approved request modified (decreased), NOA required Explanation
☐ Additional documentation or information is requested:

Comments/Reason for Denial/Reason for Re-Authorization:

_____
Authorizing Adult UM Staff Signature/Printed Name (LPHA only) Date of Decision

_____ _____
Co-Signature/Printed Name (if necessary) Date