SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

Timely Access
(MH and SUD)

MR#:
Name:

☑ **Required only for new clients:** MH Non-Psychiatry (Non-Medication) services, SUD services
☑ **Required for new AND existing clients**: MH Psychiatry (Medication) services

Request Information

Client Information			
Client Legal Name			
Client Preferred Name (if different from Legal Name)			
Client Birth Date		**Medical Record #**	

Date of Request			
Date of Request		**Time of Request**	
Discharge/Release from (if applicable)	☐ Emergency Department ☐ Inpatient ☐ Custody (Justice Involved)		
Date of Actual or Projected Discharge/Release (if applicable)			

Urgency	
Was this Request Initially Received as an Urgent Request?	☐ Urgent ☐ Not Urgent (Standard)
Updated Urgent Status (if changed from original status)	☐ Urgent ☐ Not Urgent (Standard)
Name and Discipline of Staff who Updated Urgent Status	
Reason for Change in Urgent Status (must be completed by registered/waivered/licensed LPHA)	

Program Receiving Request	
Program Name	
Staff Completing Form	

Requestor Information			
Request Received Via	☐ Call ☐ Walk-In ☐ Fax ☐ Email ☐ EHR ☐ Mail		
Referral Source (If "Other" please specify)	Choose Item		
Requestor Name		**Agency/Program**	
Requestor Relationship to Client			
Requestor Phone		**Requestor Email**	

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Appointment Information

Type of Service		
Service Requested	Choose Item	Choose Item
Referred to (Name of Program/Agency/OON)		

Prior Authorization			
Date of Authorization		**Time of Authorization**	
Determination	Choose Item		

Initial Appointment			
First Offered Appt Date		**First Offered Appt Time**	
If offered appointment was beyond standard… • Select reason for delay: Choose Item • If Other, please specify:			
First Attended Appt Date		**First Attended Appt Time**	

Follow Up Appointment (First appointment after initial attended appointment) – not required for psychiatry			
First Offered Appt Date		**First Offered Appt Time**	
If offered appointment was beyond standard, did the licensed health care provider determine the extended waiting time was clinically appropriate? Choose Item • If yes to above, explain why the delay was clinically appropriate: • Name/Discipline of clinical staff who determined the above:			
First Attended Appt Date		**First Attended Appt Time**	

Closure Information	
Date of Service Closure	
Closure Reason (If "Other" please specify)	Choose Item **If transferring to another BHRS Program, provide this form to the other program to complete if client has not reached the end of Timely Access process at time of transfer.**

Print Name and Discipline of staff completing form

Signature of Staff completing this form Date