Department of Public Health

London N. Breed
Mayor of San Francisco

Behavioral Health Services - Central UM
887 Potrero Ave, San Francisco, CA 94110

Email: BHSCentralUM@sfdph.org
FAX: (628) 206-7597

Placement Authorization Request Form

Client Name (AKA if known) _____ SSN _____ DOB _____ BIS Number (if available) _____

Client's current locations _____ Provider RU# (if known) _____

Is Client a SF resident? ☐ Yes ☐ No Where was client last 30 days? _____

Entitlements: ☐ Medi-Cal ☐ Medicare ☐ SSI Other Income Source: _____

Conservator Status: ☐ T-Con ☐ Permanent LPS ☐ Probate Conservator Name: _____

Client can effectively manage ADLs without restrictions ☐ Yes ☐ No If incontinent, can client effectively manage self-care? ☐ Yes ☐ No

SPR CLIENT: ☐ Yes ☐ No ☐ Pending PLEASE NOTE, IF SPR CLIENT, APPROVAL IS REQUIRED

SPR Clinician _____ Telephone # _____

HAS ICM: ☐ Yes ☐ No ☐ Pending ICM Clinician _____ Telephone # _____

Level of Care Requested: _____ DSM V Diagnosis Code(s) _____

Clinical Indications for Level of Care Request _____

Recommended Treatment Goals _____

Submitted By: _____ Date: _____

Telephone #: _____ Fax #: _____

PLACEMENT RECOMMEDATIONS ☐ **PLACEMENT AUTHORIZED** ☐ Med Supported Detox

☐ AOD DDx Res ☐ MH DDx Res ☐ Transitional Res ☐ LSAT ☐ Clay/Loso ☐ AOD Satellite ☐ RCF/E

☐ AOD Social Model Detox ☐ AOD Social Model Res ☐ Co-Op ☐ Support Service Hotel ☐ Hotel ☐ DAH

SPECIFY _____

☐ **NOT AUTHORIZED** REASON: _____

Authorizing Clinician _____ Date _____

Updated: 07/2022