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

Adult Residential Authorization Form

Client Name	DOB	MH#

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		CAMINAR REDWOOD HOUSE CRISIS RES 418400		
	MATEO LODGE WALLY'S 419900				
	CIELO HOUSE 41E800				

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 ☐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