



**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](mailto: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:** \_\_\_\_\_