Stay Review Justification

Client Name: _____ Admission Date: _____

Client I.D. #: _____

Client's progress in treatment during the past six months (detailed & descriptive):

Medical/psychological reasons to continue treatment (include DSM criteria for substance use disorder)

Consequences of discontinuing treatment:

Target date for client to complete treatment: _____

Verification of continued Medi-Cal eligibility confirmed by program ☐ yes, see file for M/C eligibility report(s).

What is expected to be achieved during continued treatment: **(MUST include Client's Prognosis)**
Client's Prognosis is: Good ☐ Fair ☐ Poor ☐ (elaborate)

Counselor's Name (Printed): _____

Counselor's Signature: _____ Date: _____

Stay Review Justification

Client Name: _____

Below to be completed by Medical Director

☐ **CONTINUED SERVICES ARE MEDICALLY NECESSARY AND THE FOLLOWING HAVE BEEN CONSIDERED**:

- ☐ The client's personal, medical, and substance use history
- ☐ Documentation of the client's most recent physical examination
- ☐ The client's progress notes and treatment plan goals
- ☐ The therapist's or counselor's recommendation
- ☐ The client's prognosis

☐ **CONTINUING SERVICES FOR THE BENEFICIARY IS NOT MEDICALLY NECESSARY, THE BENEFICIARY MUST BE DISCHARGED FROM TREATMENT.**

Medical Director's Name (printed):_____

Medical Director's Signature: _____ Date: _____