Specialty Mental Health Service Authorization Request (SAR) RE: Foster Child Placed Out-of-County (SB 785)

PART 1	MHP CONTACT INFORMATION		
County of Origin		**Host County**	
County of Origin (MHP)		Host County (MHP)	
County of Origin (Contact)		Host County (Contact)	
County of Origin (Tel)		Host County (Tel)	
County of Origin (Fax)		Host County (Fax)	

PART 2	BENEFICIARY INFORMATION				
Client's Name		D.O.B.		CIN or SSN	
Address		City		Zip Code	
Assessment Date		Service Start Date			

PART 3	COUNTY OF ORIGIN AUTHORIZATION TO HOST COUNTY

This authorization is issued by the county of origin to the host county in conformance with CCR 1830.220, Authorization of Out-of-Plan Services. The host county, subject to this authorization will meet the requirements of 1830.220 on behalf of the county of origin for the covered beneficiary that has been placed and referred for non-urgent mental health assessment. The host county will provide or arrange for this assessment consistent with regulation and MHP Contract requirements.

PART 4	HOST COUNTY MHP PROVIDER INFORMATION *I attest that a clinical assessment was performed for the above foster child seeking treatment with our program. The specialty mental health services proposed or to be provided to this foster child are based on meeting medical necessity.*			
Clinic / Program		**Address**		
Tel		**Fax**		**Date**
Clinician Name / Title		**Clinician Signature**		

PART 5	COUNTY OF ORIGIN MHP AUTHORIZATION APPROVAL		
Based on the attestation of Host County that the above named foster child meets Medi-Cal Medical Necessity, the County of Origin, hereby <u>authorizes basic mental health services</u>, (excluding TBS, Day Treatment, Katie A., IHBS, and other intensive service programs) as allowed under Welfare and Institutions codes for a period of 12 months.			
Authorized by (Printed Name/ License):		**Phone Number**	
County of Origin (MHP) Representative's Signature		**Date**	

COMPLETE ONLY IF COUNTY OF ORIGIN IS ASSUMING THE RESPONSIBILITY TO PROVIDE SERVICES AND REQUESTING CURRENT SERVICES TO DISCONTINUE AND CLIENT BE REFERRED TO COUNTY OF ORIGIN'S DESIGNATED PROVIDER BELOW

Please FAX Authorization back to <u>Host County MHP Contact</u> listed on PART-1