HUMBOLDT COUNTY DEPARTMENT OF HEALTH & HUMAN SERVICES
BEHAVIORAL HEALTH
1242–ARTS/CRTS AUTHORIZATION

Client Name:	**Client ID:**
Type of Request: ☐ **Initial/Referral** ☐ **Continuation**	**Date of Request:**
Client address:	**Client DOB:** **Client Medi-Cal #:**
Client Social Security Number:	**Legal Guardian:**
Client Phone:	**Guardian Phone:**

Services: **Provider:**

☐ Adult Residential Treatment
☐ Crisis Residential Treatment

Rationale:

Describe clinical rationale (medical necessity) for services authorized, including diagnosis and specific functional impairments related to the diagnosis:

Copies of clinical documentation attached: ☐ Yes ☐ No

For DHHS-BH Use Only:

Date Received:	**Authorization Decision:** ☐ Approved ☐ Denied
Authorization Number:	**Authorization Period: From: To:**

If denied, provide rationale for denial:

Date NOABD sent:

Note: If services that were previously authorized are now being denied, DHHS-BH will work with Provider to transition services; services will not be discontinued without a clear plan of care.

Comments:

Signature: ____________________________ Date:

Name, Title:

Date Completed Authorization form was sent to Provider:

Sent by ☐ Fax ☐ Mail ☐ Email