COUNTY OF LOS ANGELES
Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL
SERVICE AUTHORIZATION REQUEST FORM

Mail: Substance Abuse Prevention and Control
1000 S. Fremont Ave, Bldg. A9 East, 3rd Floor, Alhambra, CA 91803

Website: http://publichealth.lacounty.gov/sapc/
Fax: (xxx) xxx-xxxx

To check submission status call: (xxx) xxx-xxxx

1.(Check One): ☐ Preauthorization ☐ Authorization ☐ Expedited Authorization ☐ Reauthorization (Provide Current Authorization #:)			
2. Admission Date (if different from submission date):	3. Submission Date:	4. Submission Time:	5. Dates Service Requested: From:_____ To:_____

PATIENT INFORMATION

6. Name (Last, First, and Middle):	7. Date of Birth (MM/DD/ Y):	8. Medi-Cal Number: Verified Eligibility: ☐ Yes No
9. Address:		
10. Phone Number: Okay to Leave a Message? ☐ Yes ☐ No		11. Gender: ☐
12. Perinatal Patient: ☐ Yes ☐ No *Verification Required	13. Criminal Justice Involved Patient: ☐ Yes ☐ No If yes, provide verification with Criminal Justice Identification numbers.	14. Race/Ethnicity (Optional):

PROVIDER AGENCY INFORMATION

15. Provider Agency Name:	16. Phone Number:	17. Fax Number:
18. Address:		19. Email Address:
20. Name and Work Title of the Contact Person:		21. Phone Number of the Contact Person:

ORDERING PRESCRIBER (FOR MEDICATION-ASSISTED TREATMENT)

22. Name and Credential of Prescriber:	23. Phone Number:
24. Address:	25. Fax Number:

26. REQUIRED CLINICAL INFORMATION – DIAGNOSTIC AND STATISTICAL MANUAL (DSM)- 5 DIAGNOSES

27. CARE REQUESTED (CHECK ONE)

☐ 3.1 Clinically Managed Low-Intensity Residential Services: 24-hour structure with available trained personnel; at least 5 hours of clinical service/week and prepare for Outpatient treatment.

☐ 3.3 Clinically Managed Population-Specific High-Intensity Residential Services (this level of care is not designated for adolescent populations): 24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.

☐ 3.5 Clinically Managed High-Intensity Residential Services: 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community.

Medication-Assisted Treatment for Youth Under Age 18

28. REQUIRED DOCUMENTATION

FOR PREAUTHORIZATION: Submit application for pre-authorized residential services prior to initiation of services. Required documents: 1. Authorization request form. 2. Assessment information.

FOR REAUTHORIZATION: Reauthorization request must be submitted at least 7 calendar days in advance of the end date of current authorization. Required documents: 1. Authorization request form. 2. Current treatment plan. 3. Assessment information. 4. Progress notes. 5. Relevant laboratory test results (if available). 6. Verification of perinatal status and/or criminal justice status (if applicable).

INTERNAL SAPC USE ONLY

☐ Approved (Authorization #:_____) ☐ Denied

If denied, reason(s):_____

Reviewed by:_____ Date:_____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions Code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without the prior written authorization of the patient/authorized representative to who it pertains unless otherwise permitted by law.

Client Name:_____ **Medi-Cal ID:**_____

Treatment Agency_____

SERVICE AUTHORIZATION FORM INSTRUCTIONS

1. Check the appropriate box for what is being requested: preauthorization, authorization, expedited authorization or reauthorization. If requesting a reauthorization, enter the current authorization number.

   *Expedited Authorization: For cases in which a provider indicates, or the SAPC determines, that following the standard timeframe could seriously jeopardize the patient's life or health or ability to attain, maintain, or regain maximum function, the SAPC must make an expedited authorization decision and provide notice as expeditiously as the patient's health condition requires and no later than 3 working days after receipt of the request for service.
2. Enter the admission date for patient, if different from submission date.
3. Enter the submission date of when the Service Authorization Request Form was submitted.
4. Enter the submission time
5. Enter the dates for service requested: enter the date the requested service will begin and the date the requested service will end.
   - *Note: the duration for the initial residential authorizations cannot exceed 60 calendar days; the duration for residential reauthorizations and authorizations for medication-assisted treatment for youth under age 18 cannot exceed 30 calendar days.*

PATIENT INFORMATION

6. Enter the patient's name in the order of last name, first name, and middle name.
7. Enter the patient's date of birth.
8. Enter patient's Medi-Cal number and indicate if Medi-Cal eligibility has been verified.
9. Enter patient's address.
10. Enter the patient's phone number. Check box to indicate if it is okay to leave a message at this phone number.
11. Enter the patient's gender.
12. Check box if the patient is a perinatal patient. Must provide verification of perinatal status by submitting a written statement from the physician, physician's assistant, certified nurse midwife, nurse practitioner, or designated medical or clinic personnel with access to the patient's medical records. The statement must give the estimated date of confinement or the last date of pregnancy and provide sufficient information to substantiate the diagnosis. Authorization for the perinatal patient can be up to the length of the pregnancy and postpartum period which is 60 days after the pregnancy ends based on medical necessity.
13. Check box if the patient is a criminal justice (CJ) patient. Must provide any form of documentation that includes the patient's Superior Court Case number, Probation PB number, Los Angeles County Jail Criminal Information Index (CII) number, or California Department of Corrections identification number.
14. Enter the patient's race/ethnicity (optional).

PROVIDER AGENCY INFORMATION

15. Enter the name of the provider agency that is requesting the authorization or reauthorization.
16. Enter the phone number of the provider agency.
17. Enter the fax number of the provider agency.
18. Enter the email address of the provider agency.
19. Enter the address of the provider agency.
20. Enter the name and the work title of the person who can be contacted regarding the request.
21. Enter the phone number of the provider agency's contact person.

ORDERING PRESCRIBER (FOR MEDICATION ASSISTED TREATMENT)

22. Enter the name and credential of the prescriber.
23. Enter the prescriber's phone number.
24. Enter the prescriber's address.
25. Enter the prescriber's fax number.

REQUIRED CLINICAL INFORMATION – DIAGNOSTIC AND STATISTICAL MANUAL DIAGNOSES

26. Enter the DSM-5 diagnoses. At least one diagnosis must be for a substance use disorder.

LEVEL OF CARE REQUESTED

27. Check the appropriate box for the level of care requested
    - 3.1 Clinically Managed Low-Intensity Residential Services: 24-hour structure with available trained personnel; at least 5 hours of clinical service/week and prepare for Outpatient treatment.
    - 3.3 Clinically Managed Population-Specific High-Intensity Residential Services (this level of care is not designated for adolescent populations): 24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.
    - 3.5 Clinically Managed High-Intensity Residential Services: 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community.
    - Medication Assisted Treatment for patients under age 18.

REQUIRED DOCUMENTATION

28. Preauthorization or reauthorization:
    - For preauthorization: Submit application for preauthorized residential services prior to initiation of services. Required documents: 1. Service Authorization Request Form. 2. Assessment information.
    - For authorization for Medication-Assisted Treatment (MAT) for patient under age 18: 1. Service Authorization Request Form. 2. Assessment information. 3. Justification for the prescribed medication(s): name, dosage, route, frequency, duration, and relevant laboratory results (if available). 4. Relevant prior history.
    - For reauthorization: Required every 30 calendar days. Reauthorization request must be submitted at least 7 calendar days in advance of end date of current authorization. Required documents: 1. Service Authorization Request Form. 2. Current treatment plan. 3. Assessment information. 4. Progress notes. 5. Relevant laboratory test results (if available). 6. Verification of perinatal status and/or criminal justice status (if applicable).
    - For reauthorization for Medication Assisted Treatment (MAT) for patient under age 18. Required every 30 calendar days. Reauthorization request must be submitted at least 7 calendar days in advance of end date of current authorization. Required documents: 1. Service Authorization Request Form. 2. Current treatment plan. 3. Justification for the prescribed medication(s): name, dosage, route, frequency, duration, and rationale. 4. Assessment information. 5. Progress notes. 6. Relevant laboratory test results (if available). 7. Verification of perinatal status and/or criminal justice status (if applicable).

INTERNAL SAPC USE ONLY

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SUBMIT THE AUTHORIZATION REQUEST FORM TO:

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