COUNTY OF LOS ANGELES
Public Health

SUBSTANCE ABUSE PREVENTION AND CONTROL
RECOVERY BRIDGE HOUSING (RBH) AUTHORIZATION
REQUEST FORM

1. Today's Date:	2. Admission Date:	
PATIENT INFORMATION		
3. Name: (Last, First, and Middle)	4. Date of Birth (MM/DD/YY):	5. Medi-Cal or My Health LA Number:
6. Address:		7. Is the patient homeless? ☐ Yes ☐ No
8. Phone Number: Okay to Leave a Message? ☐ Yes ☐ No		9. Gender:
10. Perinatal patient: ☐ Yes ☐ No If yes, provide verification		11. Criminal Justice Involved Patient: ☐ Yes ☐ No If yes, provide verification with Criminal Justice Identification Number: _____
OUTPATIENT TREATMENT PROVIDER INFORMATION		
12. Provider Agency Name:	13. Please check if: ☐ Outpatient (ASAM level 1.0) ☐ Intensive Outpatient (ASAM level 2.1) ☐ Outpatient (Ambulatory) Withdrawal Management (ASAM level 1-WM) ☐ Opioid Treatment Program (aka: Narcotic Treatment Program)	
14. Address:		
15. Name of Contact Person:	16. Email Address:	
17. Phone Number of Contact Person:	18. FAX number:	
RBH AGENCY		
19. Agency Name:		
20. Address:		
21. Contact Person:		
22. Contact Person Phone Number:		
23. CHECK ALL APPLICABLE POPULATIONS		
☐ Perinatal ☐ Active Intravenous Drug User (within the last 30 days) ☐ High Utilizer of SUD System ☐ Criminal Justice Involved ☐ Chronically Homeless		☐ Transition Age Youth (TAY population aged 18-25 years) ☐ HIV/AIDS (without alternative funding for recovery housing) ☐ Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) ☐ Stepping down from residential treatment to outpatient treatment, and still homeless. ☐ Other (depending on availability)
24. Has the patient been screened for Whole Person Care (WPC)? ☐ Yes ☐ No If no, is the patient interested?		
25. DSM–5 Diagnosis of Substance Use Disorder(s):		
26. Staff Name	27. Staff Signature	

EXTERNAL SAPC REVIEW *This section will include communication between SAPC and the agency/provider*

☐ Approved ☐ Denied ☐ Further review required

Comments:

Reviewed by: Supervisor Reviewer: Date:

INTERNAL SAPC USE ONLY *This section is reserved for internal SAPC use only.*

☐ Approved ☐ Denied ☐ Further review required

Comments:

Reviewed by: Supervisor Reviewer: Date:

MEDICAL NECESSITY AND RECOVERY BRIDGE HOUSING AUTHORIZATION FORM INSTRUCTIONS

Note: If approved, RBH will be authorized for a period of 90 calendar days, without the option for extension

1. Enter today's date.
2. Enter the date patient was admitted to RBH facility.

PATIENT INFORMATION

3. Enter the patient name in the order of last name, first name, and middle name.
4. Enter the patient date of birth.
5. Enter patient's Medi-Cal or My Health L.A. number.
6. Enter patient address.
7. Check box yes or no whether or not the patient is homeless
8. Enter the patient phone number.
9. Enter the patient gender.
10. Check box if the patient is a perinatal patient. Must provide verification of perinatal status by submitting documentation or a written statement from qualified individuals, including the physician, physician assistant, certified nurse midwife, nurse practitioner, or other designated medical or clinic personnel with access to the patient medical records. The statement must give the estimated date of confinement or the last date of pregnancy, and provide sufficient information to substantiate perinatal status. Authorization for the perinatal patient can be up to the length of the pregnancy and postpartum period, which is sixty (60) days after the pregnancy ends.
11. Check box if the patient is a criminal justice (CJ) patient. Must provide documentation from the applicable criminal justice agency (e.g., Superior Court, Probation, law enforcement, California Department of Corrections, etc.) that indicates the patient's criminal justice involvement.

OUTPATIENT TREATMENT PROVIDER INFORMATION

12. Enter the name of the provider agency.
13. Check corresponding level of service: outpatient (OP), intensive outpatient (IOP), outpatient withdrawal management (OP-WM), opioid treatment provider (OTP).
14. Enter the address of the provider agency.
15. Enter the name of the contact person.
16. Enter the contact person's email address.
17. Enter the phone number of the contact person
18. Enter the Fax number.

RBH AGENCY

19. Enter the RBH agency name.
20. Enter the RBH agency address.
21. Enter the name of the contact person at the RBH agency.
22. Enter the phone number of the contact person.

23. Check all applicable populations the patient belongs to: High utilizer of the SUD system; Perinatal patients (pregnancy to 60-days postpartum with eligibility ending on the last day of the month in which the 60th day occurs); Active intravenous Drug Users (injected drugs within the last 30 days); Chronically homeless according to HUD definition; Certain non-AB 109 criminal justice patients without alternative criminal justice funding for recovery housing; Transition Age Youth (young adults ages 18-25); HIV/AIDS patients; Lesbian, gay, bisexual, transgender and questioning (LGBTQ) populations
24. Enter if the patient has been screened for Whole Person Care.
25. Enter the DSM Diagnosis for Substance Use Order from the ASAM assessment tool.
26. Enter the name of the staff who completed the form
27. Enter the staff signature

EXTERNAL SAPC REVIEW

This section will include communication between SAPC and the agency/provider

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SUBMIT THE FORM TO:

Fax: (323)-725-2045
Phone: (626)-299-4193