

**ASSERTIVE COMMUNITY TREATMENT  
CONTINUED STAY REVIEW AUTHORIZATION REQUEST FORM  
(ACT – CSR)**

<b>To be Completed by OBH</b>										<i>Revised 7.1.16</i>			
<b>Tracking #</b>				<b>Date/Time of Receipt</b>									
<b>PROVIDER INFORMATION</b>													
<b>Provider Company Name</b>													
<b>Person Making Referral</b>								<b>Credentials</b>					
<b>Provider Phone #</b>				<b>Provider Email</b>									
<b>Provider Address</b>													
<b>CLIENT INFORMATION</b>													
<b>Recipient Name</b>								<b>SS#</b>					
<b>Age</b>				<b>DOB</b>				<b>Ethnicity</b>					
<b>Gender</b>				<b>Gender Expression</b>						<b>Marital Status</b>			
<b>Parent/Guardian</b>						<b>Phone #</b>							
<b>Address</b>													
<b>ACT CONTINUED STAY REVIEW REQUEST</b>													
<b>Admit Date</b>								<b>Last Date Authorized by OBH</b>					
<b>Requested Start Date</b>								<b>Requested End Date</b>					
<b>Medicaid Status</b>		Applied <input type="checkbox"/>		<b>Date Applied</b>				Denied <input type="checkbox"/>		<b>Date Denied</b>			
<b>Medicaid Approval/Denial Explanation</b>													
<b>Diagnosis (any changes or additions)</b>													
<b>ICD10 Code</b>													
<b>Current Medications</b>													
<b>Changes to Current Medications</b>													
<b>PRNs</b>													
<b>REASON FOR EXTENDED AUTHORIZATION</b>													
<b>Detailed reason why continued stay is necessary.</b>													
<b>Comment</b>													
<b>Detail the discharge plan as well as day of anticipated discharge. Identify outpatient provider and recommended services, living arrangements.</b>													
<b>Comment</b>													