

Region IV Acute Care Project Project Reauthorization / Continued Admission

With: (hospital/facility): _____ Date: _____ Authorizing CSB/BHA: _____

AND: Client: _____ Reauthorization Date: _____

Soc.Security or Client ID #: _____ Reauthorization Terminates: _____

*Reauthorization not to exceed 5 Days – Extensions require approval of participating CSB/Authority
and submission of additional Reauthorization form*

Check Continued	_____	Confirmed diagnosis of mental illness
Stay Criteria Met:	_____	Clinical evidence indicates persistence of symptoms that caused initial admission, or remain despite therapeutic efforts, or due to the emergence of new symptoms (daily progress note required)
	_____	Severe reaction to medication or further monitoring/adjustment of dosages (daily progress note is required)
	_____	Clinical evidence that discharge planning, progressive increase in privileges, or attempts for a therapeutic re-entry into a less restrictive environment, has resulted in an exacerbation

The client identified above is being referred to your facility for continued acute psychiatric in-patient treatment as per the terms and conditions of the Regional Acute Care Project. Payment will be made by the referring Community Services Board / Behavioral Health Authority as per the Regional Agreement. This includes per diem rates for psychiatric care and in-patient services. Any other charges, including those for non-psychiatric medical problems, are specifically excluded. The referring Community Services Board/Behavioral Health Authority shall determine the client's eligibility for extended admission under the project.

Attending Psychiatrist: _____ Telephone: _____ Pager: _____

CSB/BHA Project CM: _____ Telephone: _____ Pager: _____

Project Reauthorization Approval CSB/BHA Authorizing Representative: _____
(Signature)

<i>Copy(s) to:</i>	CSB/BHA	Admitting Hospital	Regional Authorization Committee
			c/o John P. Lindstrom, RBHA 804-819-4265 (Fax)