Mental Health Recovery Board
Serving Warren & Clinton Counties

RESIDENTIAL SERVICE AUTHORIZATION (RSA)

Instructions:

- Case Manager/Supervisor: fill out RSA (below)
- Fax RSA to MHRB Confidential Fax: 513-695-1776 Attn: Reija Huculak at least 24 hours prior to admission
- MHRB will fax Request Status to originating fax within 48 hours or next business morning by Noon if weekend/holiday request.

Client Name:	DOB:	Client UCI:
Form Completed by: (CM Name)	CM Contact Phone Number:	CM Fax Number:
Resident's County of eligibility:	Date Faxed:	Client Primary Diagnosis

CURRENT FACILITY: ____________________ **FACILITY REQUESTED:** ________________

HOUSING ASSESSMENT RESULTS: DLA Housing Score:_____ Date of DLA:_____

VERIFICATION REQUESTED BED IS AVAILABLE ☐Yes ☐No If yes, list name: ______

LENGTH OF STAY PROJECTED OR REQUESTED (check one) ☐30 Days or Less ☐3 Months
Initial step down/transition may be approved max 30 days

PLAN AFTER 30 DAY STEP DOWN PLACEMENT: _____________________________________

START DATE: _____
IS THIS A CONTINUED STAY REQUEST? ☐Yes ☐No If yes, why? ___________________

____

CLIENT FINANCIAL STATUS: (circle all that apply) SSI $____ SS $____VA $____ RSS $__ Other ___

TOTAL MONTHLY INCOME: ☐

PAYEE: ☐Yes ☐No If yes, list name, address: ____________________________________
Has Payee been notified of the change in Residence? ☐Yes ☐No If no, when will notice
Has Payee been notified of any change in PNA amount? ☐Yes ☐No be given? _____

REASONS FOR TRANSFER/PLACEMENT: (brief narrative requested) _____

IF CHANGE OF HOUSING, HAS PREVIOUS HOUSING BEEN RELEASED? ☐Yes ☐No
If no, why?____

Case Manager Signature ______________________ **Supervisor Signature** ____________________

DO NOT WRITE BELOW THIS LINE – FOR MHRB USE ONLY

Mental Health
Recovery Board
Serving Warren & Clinton Counties

☐ **MHRB authorizes Residential Services funding reimbursement for services effective from: ___________ to: __________**

☐ **Client added to Residential Services waiting only at this time. Update required by: ______ or will be removed from list.**

☐ **MHRB does not authorize Residential Services funding reimbursement.**

Reason:

____

R. Huculak / MHRB Designated Staff **Date**