

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? _____

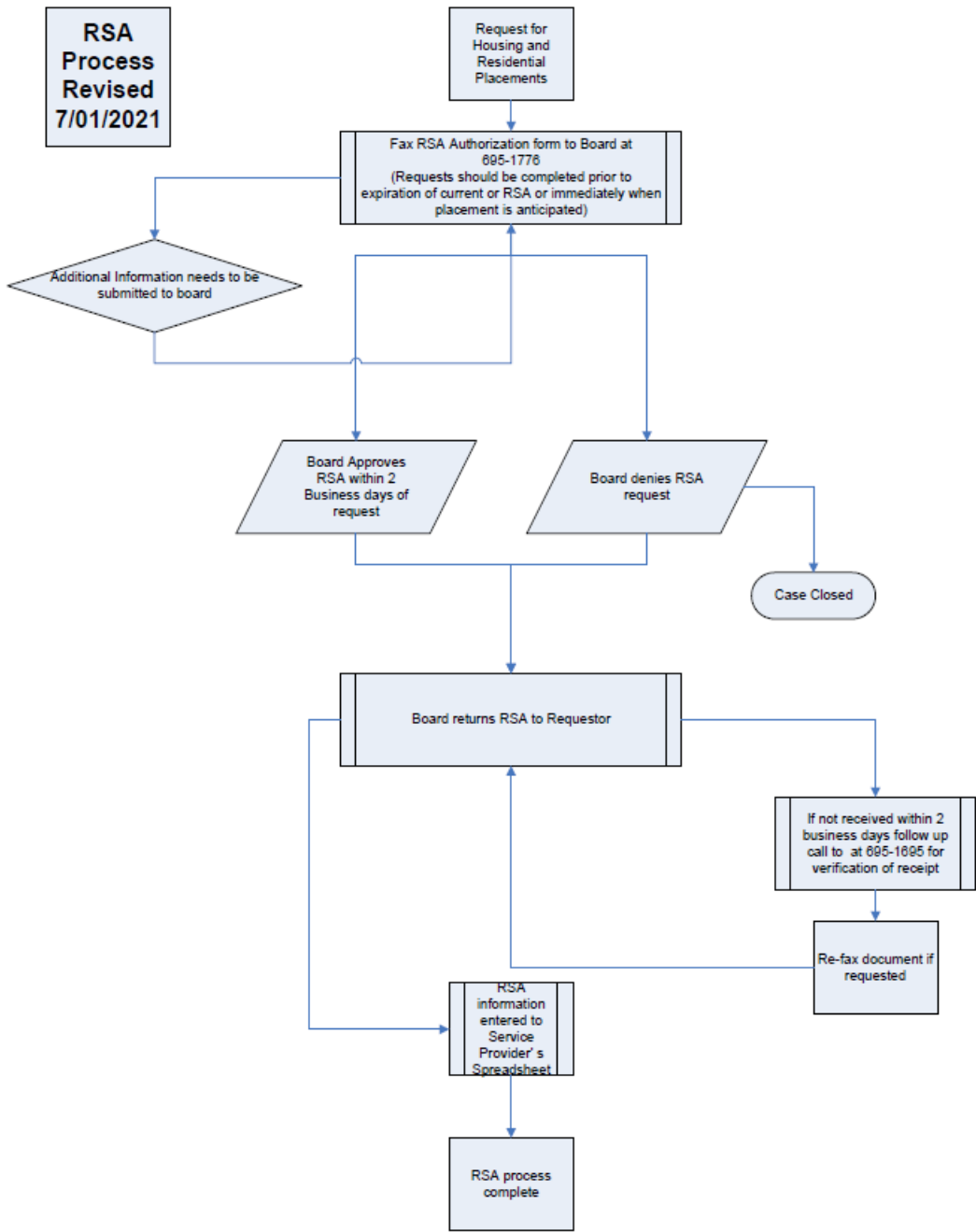
Case Manager Signature _____ **Supervisor Signature** _____

- 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



Recovery House
RESIDENTIAL SERVICE AUTHORIZATION (RH-RSA)
1/15/15

Instructions:

- AoD Therapist/Supervisor: fill out RH-RSA (below)
- Fax RSA to MHRB Confidential Fax: 513-695-1776 Attn: Jeff Rhein 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: (Therapist Name)	Therapist Contact Phone Number:	Therapist Fax Number:
Resident's County of eligibility:	Date Faxed:	Client Primary Diagnosis

CURRENT ADDRESS: _____

VERIFICATION REQUESTED BED IS AVAILABLE Yes No

LENGTH OF STAY PROJECTED OR REQUESTED 3-6 MONTHS >6 MONTHS

Legal Charges _____

Current Medications _____

TOTAL MONTHLY INCOME:

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

AoD Therapist Signature _____ **Supervisor Signature** _____

DO NOT WRITE BELOW THIS LINE – FOR MHRB USE ONLY

<input type="checkbox"/> MHRB authorizes Residential Services effective from: _____ to: _____
<input type="checkbox"/> Client added to Residential Services waiting only at this time. Update required by: _____ or will be removed from list.
<input type="checkbox"/> MHRB does not authorize Residential Services
Reason: _____
Jeff Rhein _____ Date Director of Alcohol & Drug Addiction Services



Complete RH- RSA and fax to NHO at 513-554-0514 and also to Jeff Rhein at MHRB at 513-695-1776

Client will be responsible for working with the NHO staff on payment of required fees and actually moving into the facility, once there the client can still receive the necessary outpatient AoD treatment services at the nearest location so work on transfer if not already completed. Even if client has own transportation and feels that it makes sense to live in CC and get services at WC, transfer really should be discussed with client and supervisor.