

Requesting Managed Care Authorization for Out of County Youth Services

HSA and/or Probation complete SAR to refer Merced Co youth to Out of County Outpatient services.

Below you will find steps for completing required fields to process SAR for authorization:

- on p1, top box is required
 1. "Client name" (must match name on Medi-Cal card)
 - Ensure DOB is correct
 - Enter either social security number or Medi-Cal ID #
 2. For "Requesting Agency" (agency that will be providing the services)
 - Include Service Provider Agency/County
 - Include contact person for that agency
 - Include contact number and fax
 3. For "Submitted to MHP"-which county is financially responsible
 - For Merced Co youth, choose "Merced"

- on p2 (bottom box) the following is needed:
 - Identify County of Responsibility (ie Merced Co youth)
 - Provide Social Worker/ Probation Officer Name and Contact Info (and email)

This identifies legal holder of privilege and who will sign legal paperwork to initiate services.

 - Identify what county the client is residing/placed
 - Provide Placement Info (type)
 - Foster/Guardian/group home Name and point person
 - Address
 - Phone Number
 - Identify if this is an expedited request
 - If Med Services are being requested ASAP include a statement to justify this.

- on p3 –" Authorized by "(refers to MHP Managed Care)

✓ PDF SAR can be SAVE AS – Rename file.
 Attach pdf and email to Merced Co BHRS Managed Care: PMedina@co.merced.ca.us

OR

✓ Select Envelop Icon (this attaches document to email)
 email to Merced Co BHRS Managed Care: PMedina@co.merced.ca.us



State of California - Health and Human Services Agency
 SB 785 Service Authorization Request
 MH 5125 (rev. 3/09)

Department of Mental Health
 Print Form

Service Authorization Request

For out-of-county organizational providers only.

Client's Name:	DOB:	Age:	CIN OR SSN:
(First) (Middle) (Last)			
Requesting Agency:		Contact Person:	
Contact Phone Number:		Contact Fax Number:	
Submitted to (MHP):		Date Submitted:	
Merced			

State of California - Health and Human Services Agency
 Department of Mental Health

Client Name: , Record/Identification Number:

Specialty Mental Health Service(s) Requested	Frequency of Service(s) (Indicate how many AND select the Frequency)	Total Minutes Requested	Start Date	End Date	MHP Authorization (Initial approved service)
<input checked="" type="checkbox"/> Assessment	per <input type="radio"/> Week <input type="radio"/> Month Authorization				
<input checked="" type="checkbox"/> Plan Development	per <input type="radio"/> Week <input type="radio"/> Month Authorization				
<input type="checkbox"/> Individual Therapy	per <input type="radio"/> Week <input type="radio"/> Month Authorization				
<input type="checkbox"/> Group Therapy	per <input type="radio"/> Week <input type="radio"/> Month Authorization				
<input type="checkbox"/> Collateral Services	per <input type="radio"/> Week <input type="radio"/> Month Authorization				
<input type="checkbox"/> Family Therapy	per <input type="radio"/> Week <input type="radio"/> Month Authorization				
<input checked="" type="checkbox"/> Targeted Case Mgmt	per <input type="radio"/> Week <input type="radio"/> Month Authorization				
<input checked="" type="checkbox"/> Medication Support	per <input type="radio"/> Week <input type="radio"/> Month Authorization				
<input type="checkbox"/> Other:	per <input type="radio"/> Week <input type="radio"/> Month Authorization				

Explain why this service level is necessary. If the above services are in addition to day treatment, day rehabilitation services, explain why additional services are needed:

- Youth is ward of Merced Co
- SW Jane Doe: 209-385-#### fax: 209-385-### jdoe@co.merced.ca.us
- Youth is placed in Santa Clara foster home:
- Address
- Phone Number
- Please expedite authorization youth has been given 7 day notice.
- Med Services are being requested due to running out of psych meds and PCP will no longer prescribe.