Revised 1/14/15

Health Planning Region I LIPOS Fund Authorization

Client Name: _____ SSN _____

Date of Birth: _____ Phone Number: _____ Gender: M / F

Address: _____

City: _____ State: _____ Zip:_____

Is Case Open to CSB? Y / N CSB of Origin/Out of Catchment: _____

Known History of State Facility Admissions Y / N

Current Inpatient Admission Date: _____ Current Commitment Date: _____

Commitment Status:(check one) _____ Involuntary Commitment _____ Court Ordered Voluntary

Use of SA Diversions Funds: Y/N Number of Days: _____

*Maximum total LOS for combined funding cannot exceed 4 days

The above named individual's inpatient acute psychiatric care will be paid at the established per diem rate to the following provider:

Name of Provider:_____

For the following dates (not to exceed 4 days total) if the individual continues to remain in the acute care facility:

Dates (month/day/year) _____

Authorizing CSB: _____

Submit for payment to the above-identified CSB to the following individual or department:

Name/Dept.: _____

Address: _____

City _____ State_____ Zip _____

The signature below validates authorization of the use of diversion funds for the cost of care for the above-named individual.

_____ _____

CSB MH Director or Designee Date

Fax to: Local Acute Care Provider and the HPR I Regional Office (f): (434)970-1492