Substance Abuse Treatment Provider Recommendation to CWS

Department of Social Services

Pre-Authorization to Provide Alcohol or Drug Treatment Services

TP ☐ FS ☐
RP ☐ RWH ☐
PP ☐ TC ☐
ODF ☐ LRC ☐
PTOX ☐ CDF ☐

☐ **Good Samaritan**

Contact Name:
Phone:
Fax:

☐ **Coast Valley**

Contact Name:
Phone:
Fax:

☐ **CADA**

Contact Name:
Phone:
Fax:

Date:

To: <DROP>

Social Worker:

Recommendation of Provider:

This is to notify you that the following treatment services are being recommended for *(include number and frequency):* **Client Name:** **Client DOB:**

DESCRIPTION	#		$	MO. TOTAL
# of Individual(s) per MONTH		X		$0.00
# of Group(s) per WEEK		X		$0.00
# of Random Full Panel Drug Tests per WEEK		X		$0.00
# Single Drug Test(s) per WEEK		X		$0.00
# of Bed Days		X		$0.00
TOTAL COST PER MONTH:				$0.00

have been authorized for the period of to **not to exceed three months.**

TOTAL COST FOR MONTH PERIOD: **$0.00**

After the time period has expired or the specified number of services have been provided, the contractor is responsible for costs incurred during any lapse in treatment authorization. Additionally, DSS will not pay for any services not designated in our contract with your organization.

Provider will submit monthly report to: <DROP>

Funding Source To Be Completed By Provider AND CWS:

☐ EA ☐ PC 1000 ☐ Medi-Cal ☐ CalWORKs ☐ PSSF ☐ STOP ☐ Block Grant

Signature of Assigned Case Manager ***Printed Name of Representative*** ***Phone #*** ***Date***

To be completed by Social Worker:

Next court date: _____ Service Component: _____ FDTC: _____

Hearing Type: _____

Any modifications to recommendation:

Signature of Assigned Social Worker ***Printed Name of Representative*** ***Date***

Signature of Assigned Supervisor ***Printed Name of Representative*** ***Date***

Signature of Division Chief ***Printed Name of Representative*** ***Date***

Social Worker: return within 2 days to Lisa DiLullo or Veronica Romero for faxing to Provider.