EL DORADO COUNTY
HEALTH AND HUMAN SERVICES AGENCY
Behavioral Health- Substance Use D

Substance Use Disorder Services
Treatment Authorization Form

Client Name: _____ **Avatar #:** _____

Provider:

☐ **PROVIDER NAME**

Authorized Dates: _____ **to** _____

Funding Stream: _____

☐ **Outpatient**
*by # of units

☐ Individual Counseling* #: _____
☐ Group Counseling* #: _____
☐ Family Counseling* #: _____
☐ Intensive Outpatient
# of days: _____

☐ **Residential Treatment w/ Room and Board** _____ Days
☐ **Withdrawal Management** _____ Days
☐ **Recovery Residences** _____ Days

☐ Substance Abuse Testing* : Type: _____ #: _____

Comments: _____

_____

_____

Assigned Case Manager: _____

Authorization By:

_____ _____
Signature Date

_____
Name Title

Substance Use Disorder Services
Phone: (530) 621-6146 /Fax: (530) 295-2596
Email: sudsqualityassurance@edcgov.us

Office Use Only