Behavioral Health Administration

RESIDENTIAL REHABILITATION PROGRAM LEVEL OF CARE CHANGE FORM

RRP Provider Requesting Change: _____

Consumer's Name: _____ Date of Birth: _____
County: _____
Program: _____
Current Level of Care: ☐ General ☐ Intensive
Requested Level of Care: ☐ General ☐ Intensive
Current RRP Category: ☐ Adult Specialty: _____
Requested RRP Category: ☐ Adult Specialty: _____

Reason for request: _____

_____

_____

_____

_____

Anticipated time frame for new level of service: _____

Requested by: _____
Title: _____
Phone number: _____
Fax number: _____
Date: _____

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Core Service Agency/Local Behavioral Health Authority Approval

Approval: _____ Yes _____ No Date: _____

CSA/LBHA Signature: _____

Printed Name: _____

CSA/LBHA must approve prior to change in authorization