Fax Form to:
HMHR Team, 206-973-8517
Email Form to:
Continuing.stay@kingcounty.gov

Alternative Benefit Coverage Authorization Request for SL, LTR, ICSRP, or E-ICSRP Clients

Client name: KCID:

SL / LTR / E-ICSRP Facility: Medicaid Funding: SELECT ONE

Provider One: MCO:

Financial Resources: SELECT

Requested Benefit: SELECT

Reason:

Plan to assist client with Medicaid Application or SSI application:

Individual's current income?

Duration of requested funds:

Anticipated move-in date:

Facility Staff completing form Phone number Email Date

THIS SECTION TO BE COMPLETED BY MENTAL HEALTH UTILIZATION MANAGEMENT TEAM

KING COUNTY AUTHORIZATION: _____ DATE: _____