Fax to: HMHR Team, 206.973.8517
Email to: continuing.stay@kingcounty.gov

King County

RESIDENTIAL ABSENCE AUTHORIZATION

CLIENT'S NAME:	FACILITY NAME:	KCID:	DOB:
FORM COMPLETED BY:	PHONE:	DATE SUBMITTED:	

DATE CLIENT LEFT:

ABSENCE REASON

- HOSPITALIZATION (BEYOND FIVE WORKING DAYS)
  - MEDICAL (name of hospital):
  - PSYCHIATRIC (name of hospital):
  - DATE OF ADMISSION:
  - ANTICIPATED RETURN DATE:
- SOCIAL LEAVE (BEYOND FIVE WORKING DAYS)
  - ☐ PLANNED LEAVE ☐ UNPLANNED LEAVE
  - CONSISTENT WITH CLIENT'S ISP? ☐Y ☐N
  - CLIENT'S CURRENT LOCATION:

    ☐JAIL

    ☐CD INPATIENT

    ☐UNKNOWN

BED TO BE HELD UNTIL:

THIS SECTION TO BE COMPLETED BY MENTAL HEALTH RESIDENTIAL UM SUPERVISOR

APPROVED FOR RESIDENTIAL BED HOLD? ☐Y ☐N BED TO BE HELD UNTIL: _____

KING COUNTY AUTHORIZATION: _____ DATE: _____