SACRAMENTO COUNTY

Crisis Residential Program (CRP) – Extension Request

1. Extension Request Information:

SmartCare #: _____ Today's Date: _____

CRP Location: ☐ TP CRP – Viking ☐ TP CRP – M St. ☐ TP CRP – Henrietta ☐ TAY CRP – Marconi

Referral Date:_____Admission Date: _____

Original Scheduled Discharge Date: _____ Subsequent Discharge Date: _____

Length of Extension:_____Days

2. Original Reason for Referral:

☐ Symptom Stabilization
☐ Psychosocial Stressors
☐ Other - Please explain: _____

Referral Symptoms:

☐ SI
☐ Mood
☐ Psychosis
☐ Further Symptom Stabilization
☐ Medication Stabilization
☐ Other – Please explain _____

Referral Psychosocial Stressors: _____

3. Reason for Extension Request:

☐ Medication
☐ Symptom Stabilization
☐ Psychosocial Stressors
☐ Conservatorship
☐ Medical and/or Dental
☐ Other – Please explain in box below:

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4. How extension will assist the client:
   - ☐ Continuity of Care
   - ☐ Specialty Medical or Dental Care
   - ☐ Housing Placement
   - ☐ Stabilize Symptoms
   - ☐ Prevention of Crisis and Re-Hospitalization
   - ☐ Other – Please explain in box below:

CRP Director or Designee (print Name/Title): _____

Signature & Date: _____

☐ I certify that the new client plan and all documentation reflects the reason for the extension and how the services are supporting the extension.

Sacramento County BHS Program Coordinator or Designee (print Name/Title):

_____

Signature & Date: _____

☐ Approved ☐ Not Approved