



## Crisis Residential Program (CRP) – Extension Request

1. Extension Request Information:

Avatar #: \_\_\_\_\_ 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

Housing

Psychosocial Stressors (not housing)

Conservatorship

LOCUS (Waiting for LOCUS, placement)

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