LANCASTER COUNTY DRUG & ALCOHOL COMMISSION
CONTINUED STAY REQUEST *

(*_For additional funding to extend treatment episode_)

SCA Client Number:_____
Name of Agency Requesting Extension:_____
Name of Assigned Therapist:_____
Email of Assigned Therapist:_____
Current level of care:_____
Date of Request:_____

1. Brief description of progress or lack thereof, which may include attendance, participation, development of natural supports, how/if recovery environment is conducive to recovery efforts, development of healthy coping skills, other factors that may impact treatment progress, etc.

2. For individuals prescribed an FDA approved medication for their SUD:
   a. NA* ☐
      (*If NA box is checked, only complete #3 below)

   b. Name and dosage of medication(s):_____

   c. Briefly describe the type of therapeutic interventions being utilized in conjunction with the prescribed SUD medication(s):

   d. Rationale for continuing prescribed medication:_____

   e. Rationale for continuing treatment:_____

   f. Estimated time frame for continued treatment episode: _____

3. General clinical prognosis to include **:
   (**If you completed #2 above, check this box ☐ and disregard answering letter *a* and *b* below)
   a. Recommendations/rationale to continue treatment

   b. Estimated time frame for continued treatment episode:_____

LANCASTER COUNTY DRUG & ALCOHOL COMMISSION
CONTINUED STAY REQUEST *

(*_For additional funding to extend treatment episode_)

REMEMBER: This completed document is to be emailed WITH the following three additional documents:

1. Most current fully executed, valid, signed LCDAC consent to release information
2. An updated ASAM Criteria Placement Summary Sheets with Risk Ratings
3. An updated Liability form

****

FOR LCDAC USE ONLY

Name of LCDAC Reviewer:_____
Date of Review:_____
Status of Request:_____

- Approved: ☐
  - New funding expiration date: _____
- Denied: ☐
  - Explanation for denial: _____

Date this response was emailed back to Assigned Therapist: _____