	Salish Behavioral Health Organization **Authorized Absence from Residential Treatment**						
#	**Required Information**						
1	Name of Agency		Agency NPI #		Salish BHO Provider #		
2	Client name				DOB		
3	Current DSM-5 diagnosis			Current ASAM LOC			
4	Authorized length of treatment stay						
5	Date of admission to treatment			Last covered day			
6	Dates of authorized absence from facility		Depart:			Return:	
7	Reason for client's absence:						
8	Contact requirements for client while away from facility:						
9	Activities to support client's stability while away from facility:						
10	Scheduled date and time of client's return		Date:			Time:	
11	Name and title of agency supervisor approving client's absence						
12	Clinic contact #'s	Primary Counselor #:					
		Clinical Supervisor #:					
		After hours supervisor #:					
		Administrative staff #:					
13	Date and time of client's departure	Date:			Time:		
14	Date and time of client's return	Date:			Time:		
15	Comments:						