HEALTH SYSTEMS

Respite Extension Request Form

Provider Name: Click here to enter text. **Date**: Click here to enter a date.

Consumer Information:	
Name: Click here to enter text.	
DOB:	SSN:

Treatment Details:
Date of Admission:
Provider Program Type/ Service Description:
Name of facility:
Reason for Extension:
Extension Request for Number of Days:

[**Please submit all extension requests to your network manager via fax or encrypted email.**]

Contact Information:			
Agency Representative (Enter Name of Contact Person)	Phone	Fax	Email
LSF Health Systems [Please send all extension requests to your network manager]	904-900-1075	904-900-1628	[Please send all extension requests to your network manager via encrypted email]
Provider Contact			
Community Case Manager (if applicable)			
Parent/Guardian (if applicable)			

_____ _____

Provider Representative Signature LSF Health Systems Signature, **Authorizing *Extension***