

**KING COUNTY ADMINISTRATIVE SERVICES ORGANIZATION (ASO)  
ITA Extension Request for Hospitalization**

Client Name:		Birth Date:
Inpatient Facility:		
Date of Admission/Detention:		
Principal Diagnosis:		
Other Diagnoses/Medical Co-Morbidity:		
Extension Request:	First <input type="checkbox"/> Second <input type="checkbox"/> Third <input type="checkbox"/> Fourth <input type="checkbox"/> Fifth <input type="checkbox"/> Sixth <input type="checkbox"/>	

Current Symptoms/Level of functioning:	
Medication adjustments/effectiveness:	
Support Network Issues/Discharge Plan:	
Number of Extension Days Requested:	_____ days through: _____ discharge date: _____

Hospital Reviewer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Send to Crisis Connections 206-461-3247 (Fax)**

**FOR KING COUNTY ADMINISTRATIVE SERVICES USE ONLY**

Number of Extension Days Approved: \_\_\_\_\_ days through \_\_\_\_\_

Number of Administrative Days Approved: \_\_\_\_\_ days through \_\_\_\_\_

Number of Extension Days Denied: \_\_\_\_\_ days through \_\_\_\_\_

Authorizing Signature of KCASO:

\_\_\_\_\_ Date: \_\_\_\_\_

Signature of MD (for children under age 18 and all denials):

\_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_