STATE OF FLORIDA
SUBSTANCE ABUSE & MENTAL HEALTH PROGRAM
CRISIS STABILIZATION SERVICE UTILIZATION

(* Mandatory Fields) (Reference: Chapter 16, DCF Pam 155-2)

Client's Name:

1. *CONTRACTOR IDENTIFIER: ___ ___ - ___ ___ ___ ___ ___ ___ ___ Federal Tax Identification number	Page 16 - 4
2. *PROVIDER ID: ___ ___ - ___ ___ ___ ___ ___ ___ ___ (Subcontractor ID)	Page 16 - 4
3. *PROGRAM TYPE: ___ ☐ 1-AMH ☐ 3-CMH	Page 16 - 4
4. *COVERED SERVICES: <u>03</u> Use code 03 – Crisis Stabilization	Page 16 - 4
5. *FUND: <u>02</u> Use code 02 – SAMH	Page 16 - 4
6. *CENSUS DATE: ___ ___ ___ ___ ___ ___ ___ ___ (YYYYMMDD)	Page 16 – 4
7. *LICENSED BEDS: ___ ___ ___ ___ .___ ___	Page 16 – 4
8. *DCF BEDS: ___ ___ ___ ___ .___ ___	Page 16 – 4
9. *DCF CLIENTS: ___ ___ ___ ___ .___ ___	Page 16 – 5
10. *UNOCCUPIED BEDS: ___ ___ ___ ___ .___ ___	Page 16 – 5
11. *BEGINNING CENSUS: ___ ___ ___ ___ .___ ___	Page 16 – 5
12. *NEW ADMISSIONS: ___ ___ ___ ___ .___ ___	Page 16 – 5
13. *DISCHARGES: ___ ___ ___ ___ .___ ___	Page 16 – 5
14. *TRANSTYPE: ___ ☐ A- Add Record ☐ C- Change/Replace Record ☐ D- Delete Existing Record	Page 16 - 5
Signature: ______________________________ Date: ___ ___/___ ___/___ ___ ___ ___	