BRITISH COLUMBIA

Ministry of Health Services
Home and Community Care

SERVICE AUTHORIZATION ACTION MEMO

HEALTH DIST. | CLIENT NUMBER

CLIENT INFORMATION

CLIENT'S FAMILY NAME | FIRST NAME | SEX ☐ M ☐ F | BIRTH DATE Y Y Y Y M M D D

SERVICE AUTHORIZATION

SA - ID | ASSESSOR

PROVIDER ID | AUTHORIZATION DATE Y Y Y Y M M D D

ORG. | SERVICE | TYPE

☐ START — 1 ☐ PAID 2 ☐ UNPAID

CARE LEVEL | CLIENT CONTRIBUTION $ | APPROVED HRS./DAYS

☐ CHANGE — 1 ☐ BEGIN PAID ABSENCE A ☐ VACATION B ☐ ILLNESS 2 ☐ RETURN

☐ END — 2 ☐ DEATH 5 ☐ UNPAID TEMP ABSENCE

☐ CORRECT ☐ DELETE SA - ID

AUTHORIZING SIGNATURE: DATE: YYYY MM DD

SERVICE AUTHORIZATION

SA - ID | ASSESSOR

PROVIDER ID | AUTHORIZATION DATE Y Y Y Y M M D D

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HLTH 3 Rev. 2002/10/11