

**Bed Hold Extension Request**

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| --- | --- |
| Date  |       |
| Name of Facility Requesting Bed Hold |       |
| Contact Name at Facility |       |
| Contact Phone Number |       |
| Contact Fax Number |       |
| Date Bed Hold Began |       |
| Client Name |       |
| Client’s Date of Birth |       |
| Reason for Bed Hold and where the client is currently |       |
| Duration of extension requested |       |
| Will Accept Client Back | [ ]  Yes [ ]  No  |

Bed Hold Extension requests are to be sent to San Diego County BHS Leadership for approval past 7 days. Please include the Optum LTC team and Medical Director in the request.

**\*\*\*Please note bed holds and extensions are only granted when a facility anticipates accepting a client back to their facility.**