



## SNF-Bed Hold Extension Request

|                                                       |                                                             |
|-------------------------------------------------------|-------------------------------------------------------------|
| 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                               | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |

Bed Hold Extension requests are to be sent to San Diego County BHS Leadership for approval past 14 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.**