**DEPARTMENT OF MENTAL HEALTH**

**Utilization Review Committee Recommendations**

**Consumer Name:****SC Name:**

**ID Number:**

**Plan Year:****[ ] Annual** **[ ] Amendment Date Reviewed**

***Recommendations are as follows:***Click here to enter text.

**Members of UR Team:**

 **Information Due**

***Action Taken: (Response due to UR Committee by date noted above)***

***Date of Second Review:*** ***UR Committee Recommendation to Action Taken*:**

**Committee Members:**

***Summary of Recommendations:***

**[ ]  This plan needs to be reviewed in** **months.** **[ ] This plan does not require annual utilization review.**

**[ ]  Approve as Submitted**

**[ ]  Approve with Modifications**

**[ ]  Do Not Approve**

**Identify Services Recommended for Wait List:**

**U.R. Committee Chair or Designee: Date****Annual Budget $**

**UR Recommendations Approved** **[ ] Yes** **[ ] No** **[ ] Modified**

**Center Director/designee Date**

**Comments:**