**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:**