



**DEPARTMENT OF MENTAL HEALTH
Utilization Review Committee Recommendations**

Consumer Name: _____		SC Name: _____	
ID Number: _____			
Plan Year: _____	Annual	Amendment	Date Reviewed: _____
<i>Recommendations are as follows:</i>			Members of UR Team:
			Information due:
<i>Action Taken: (Response due to UR Committee by date noted above)</i>			
<i>Date of Second Review:</i> _____		<i>UR Committee Recommendation to Action Taken:</i>	
Committee Members _____			
<i>Summary of Recommendations:</i>			
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:			

Revised 04/17/06