

**YORK/ADAMS HEALTHCHOICES MANAGEMENT UNIT
CRR Room and Board Host Home
Application Request**

Applicant Name: _____
M.A. #: _____
Behavioral Health Diagnosis: _____

Current Services: _____

County of Residence: York Adams
Application Date: _____

CRR Host Home Room & Board *

* County liability required by family and referral source verification of child's SSI/SSDI benefit.

Service Provider

Service Provider: _____
Address of Provider: _____
Contact Person Name: _____
Contact Phone/Fax/Email: _____
Facility: _____

Date Placed: _____ **Date of CC Authorization:** _____
Date Auth Begins/Continue: _____ **Date Auth Ends:** _____
No. of Days Approved by CC: _____ **SSI Amount, if any:** _____
County Liability: _____ **SSDI Amount, if any:** _____

Referral Name/Title: _____
Referral Agency: _____
Referral Contact #: _____
Referral Email Address: _____

PLEASE SUBMIT COMPLETED REQUEST TO:
York/Adams HealthChoices Management Unit
Attn: 100 W. Market Street, Suite B-03, York, PA 17401-1332
717-771-9900 (office) 717-771-9590 (fax)