BRITISH COLUMBIA | Ministry of Health

SERVICE AUTHORIZATION
ACTION MEMO

HEALTH DIST.
CLIENT NUMBER

CLIENT INFORMATION

CLIENT'S FAMILY NAME
FIRST NAME
SEX ☐ M ☐ F
BIRTH DATE Y Y Y Y M M D D

SERVICE AUTHORIZATION

SA - ID
ASSESSOR
PROVIDER ID
AUTHORIZATION DATE Y Y Y Y M M D D
ORG.
SERVICE
TYPE
☐ **START** 1 ☐ PAID 2 ☐ UNPAID
CARE LEVEL
CLIENT CONTRIBUTION $.
APPROVED HRS./DAYS
☐ **CHANGE** 1 ☐ BEGIN PAID ABSENCE A ☐ VACATION B ☐ ILLNESS 2 ☐ RETURN
☐ **END** 2 ☐ DEATH 5 ☐ UNPAID TEMP ABSENCE
☐ **CORRECT** ☐ **DELETE** SA - ID
AUTHORIZING SIGNATURE:
DATE: YYYY MM DD

SERVICE AUTHORIZATION

SA - ID
ASSESSOR
PROVIDER ID
AUTHORIZATION DATE Y Y Y Y M M D D
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