1. **Date request submitted:** Click to enter date
2. **Reason for reassessment request** (select appropriate category below):

Significant and sustained increase/decrease in medical support needs over a period of 6 months:

**Please briefly describe and attached required documentation as listed below:**

Significant and sustained increase/decrease in behavioral support needs over a period of 6 months:

**Please briefly describe and attached required documentation as listed below:**

Sustained and Significant Change in any 2 Life/Activity Domains (Life Activity Domains: Parts A-F & Protection and Advocacy Section of the SIS®) **Please briefly describe and attached required documentation as listed below:**

Other: **Please briefly describe and attached required documentation as listed below:**

1. **Type of assessment being requested** (select one):

Child (ages 5–15)  Adult (ages 16 and over)

1. **Was this request reviewed by your CSB SIS® Administrator** (select one)?  Yes  No
2. **Individual’s Information:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** | **Address:** | | |
| **Date of Birth:** | **SSN:** | **Medicaid #:** | |
| **CSB Tracking#:** | **Date of Last SIS®:** | | **SIS® ID Number:** |

1. **Support Coordinator/Case Manager Information:**

|  |  |
| --- | --- |
| **Name:** | **Agency:** |
| **Phone #:** | **Phone #:** |
| **Email Address:** | |
| **Has SC known Individual for 3 months?** Choose an item | |

1. **Enter any pertinent additional information:**

|  |
| --- |
| **General Notes:** |

|  |
| --- |
| **—SECTION BELOW FOR DDS USE ONLY—** |
| 1. **Date Request Received:** Click to enter date 2. **Date of DDS Review:** Click to enter date 3. **Outcome:**  Request Rejected  Approved  Denied 4. **Notes:** 5. **DDS Reviewer Name:**       **Title:** Select Title |

Supporting documentation for SIS**®** Reassessment Request (Please indicate material included):

* For significant and sustained changes related to medical support needs, please submit:

Skilled nursing plans

Documentation of any referrals for new supports/services made by the support coordinator

Any relevant medical/physicians’ orders that corroborate the change in medical supports

All Part Vs (Plans for Support) that have changed as a result of the medical support need(s)

* For significant and sustained changes related to behavioral support needs, please submit:

Therapeutic consultation plans currently being utilized

Documentation of any referrals for new supports/services made by the support coordinator

Active crisis support and/or behavior support plans

All Part Vs (Plans for Support) that have changed as a result of the behavioral support need(s)

* For sustained and significant change in any 2 Life/Activity Domains, please submit:

Documentation of any referrals for new supports/services made by the support coordinator

All Part Vs (Plans for Support) that have changed as a result of the change in support need(s)

Special Instructions:

1. If a reassessment is being requested for *both* medical and behavioral support reasons, please submit all material as outlined above under both criteria.
2. If a reassessment is being requested for “Other” reasons – please submit any and all pertinent information relevant to the request.
3. Reassessment requests must be submitted via secure email.