1. **Date request submitted:** *Click to enter date* **RSS:** *Click to select RSS*
2. **Individual’s Information:**

| **Name:** | | **CSB:** | |
| --- | --- | --- | --- |
| **Address:** | **Medicaid: #** | | **CSB Tracking: #** |
| **Date of Birth:**  *Click to enter date* | **Date of Last SIS®:**  *Click to enter date* | | **SIS® ID Number:** |

1. **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:**

**4. Was this request reviewed by your CSB SIS® Administrator** (select one)?  Yes  No

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

|  |  |
| --- | --- |
| **Name:** | **Agency:** |
| **Phone: #** | **Phone: #** |
| **Email Address:** | |

**Enter any pertinent additional information:**

**Supporting documentation for Reassessment Request (include 6 months of supporting documentation and indicate material included).**

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

Skilled/Private Duty 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

Quarterly reports from all approved waiver services.

All relevant incident reports

Part Vs (Plans for Support) identify changes made to reflect increased/decreased support need(s). DBHDS staff will confirm via WaMS.

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

Quarterly reports from all approved waiver services.

All relevant behavior data

All relevant incident reports

Part Vs (Plans for Support) identify changes made to reflect increased/decreased support need(s). DBHDS staff will confirm via WaMS.

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

Quarterly reports from all approved waiver services.

Part Vs (Plans for Support) identify changes made to reflect increased/decreased support need(s). DBHDS staff will confirm via WaMS.

**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.

|  |
| --- |
| **—SECTION BELOW FOR DDS USE ONLY—** |
| **Date Request Received:** *Click to enter date*  **RSS Review**  Request rejected and sent back to CSB  *The current SIS® assessment was completed less than 6 months ago*  *No documentation, or documentation of less than 6 months, was submitted with the request*  Request sent to SIS® Quality Manager for DDS review  RSS Signature: *Click or tap to sign* Date: *Click to enter date*  **DDS Review:**  Approved  Denied  **Notes:**  **DDS Signatures:**  Maureen Kennedy, SIS® Quality Manager  *Click or tap to sign* Date: *Click to enter date*  Joan L. Bender, Regional Supports Manager  *Click or tap to sign* Date: *Click to enter date* |