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

| *Click to enter Name* | | *Click enter CSB* | |
| --- | --- | --- | --- |
| *Click to enter Address* | *Click to enter Medicaid Number* | | *Click to enter CSB Tracking Number* |
| *Click to enter Date of Birth* | *Click to enter last SIS Date* | | *Click to enter SIS ID Number* |

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

If no, *click to explain why?*

1. **Identify the reason for the reassessment request (select appropriate category & attach required documentation):**

Are there significant and sustained increase/decrease in medical support needs that have occurred for a period of at least 6 months? Are the changes on-going and how are the supports now provided different since the most recent SIS?

*Briefly explain how provided medical supports have changed, since the last SIS, to meet the new medical need.*

Are there significant and sustained increase/decrease in behavioral support needs that have occurred for a period of at least 6 months? Are the changes on-going and how are the supports now provided different since the most recent SIS?

*Briefly explain how provided behavioral supports have changed, since the last SIS, to meet the new behavioral need.*

Are there significant and sustained increase/decrease in at least two Life Activity Domains (Sections 2A – 2F) and/or Protection and Advocacy Section of the SIS that have occurred for a period of at least 6 months? Are the changes on-going and how are the supports now provided different since the most recent SIS?

*Briefly explain how provided supports have changed, since the last SIS, to meet the new needs.*

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

|  |  |
| --- | --- |
| *Click to enter SC Name* | *Click to enter CSB* |
| *Click to enter SC primary phone number* | *Click to enter SC alternate phone* |
| *Click to enter SC email* | |

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

*Briefly describe any additional relevant 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 RSS Received Request:** *Click to enter date*  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*  *Notes: Click here to enter additional notes.*  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:** *Click here to enter notes.*  **DDS Signatures:**  Maureen Kennedy, SIS Quality Manager  *Click or tap to sign* Date*: Click to enter date*  Kenneth Haines, Regional Supports Manager  *Click or tap to sign* Date: *Click to enter date* |