Supportive supervision re-tiering request form (CBHS)

Washington State Health Care Authority

Instructions

Please type or print clearly and fill out form completely.

TO:

Medicaid plan assigned

☐ Wellpoint: **wacbhs@wellpoint.com**

☐ Community Health Plan of Washington: **bhpc@chpw.org**

☐ Coordinated Care: **WA_Behavioral_Health_UM@coordinatedcarehealth.com**

☐ Molina: **cbhsreferrals@molinahealthcare.com**

☐ United Health Care: **wa_behavioralhealthreferrals@uhc.com**

☐ Fee-for-Service (FFS): **hca1915iservices@hca.wa.gov**

Date of request _____

FROM:

Provider's name	Email	Telephone

RE:

Client's name (as written in the CARE assessment)	Client's ProviderOne ID WA	Date of birth (mm/dd/yyyy)

HCS:

Client's HCA Case Manager	Email	Telephone

1 Re-tiering request

1. **Describe how the client's behavioral needs have changed since the last tiering decision and are not met with the current level of Supportive Supervision AND/OR Provide a summary of the information that was not considered in the previous tiering decision. Reference the tiering guidance.**

2. **List the other Behavioral Support Services the client is receiving:**

☐ **Expanded Community Services (ECS)**

☐ **Specialized Behavior Supports (SBS)**

☐ **RCS Behavioral Health Support Team (BHST)**

☐ **Outpatient services with a behavioral health agency**

☐ **Other** (describe)

3. **Include the following documentation along with the Re-Tiering Request form:**

☐ **CARE assessment details**

☐ **Behavioral Support Plan (ECS/SBS)**

☐ **Staffing and behavior logs for the past 30 days**

☐ **Other** (describe)

Tiering Decision

To Be Completed By the Authorizing Entity (MCO or HCA for FFS).

☐ **Supportive Supervision**

☐ Tier 1 (0.5 - 2 hours a day)

☐ Tier 2 (2.1 - 6 hours a day)

☐ Tier 3 (6.1 - 9 hours a day)

☐ Tier 4 (9.1 - 16 hours a day)

☐ Tier 5 (16.1 - 20 hours a day)

☐ Tier 6 (20.1 – 24 hours a day)

Service authorization from _____ to _____

MCO/HCA response and recommendations::

Signature

_____ _____

Authorizing signature | Date sent to HCS/AAA and HCA case manager

2 MCO/HCA change notification

Client changing from:

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Effective date _____

Client changing to

Medicaid plan assigned

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Attach copy of completed Community Behavioral Health Supports (CBHS) Referral Form