Region 10 PIHP Autism Waiver Benefit Case Action Request Form

Individual's Name: _____ DOB:

MED #: _____ Confirmed active: ☐ Utilizing Private Insurance: ☐Yes ☐ No

CMH: _____ CMH #:

WSA #:

Case Action Review Request:

☐Initial Evaluation ☐Re-Evaluation ☐IPOS/Update ☐Discharge

Directions: CMH Autism Coordinator/Designee to complete all required sections *within the area of requested review only*, and sign. Upon completion, post to corresponding CMH folder in SharePoint.

Requestor: _____ Phone Number:

(Accepted as electronic signature)

Initial/Re-Evaluation

Completed by CMH	PIHP
Referral Date: _____ Eval Start Date:	Criteria Met?
ADOS-2 Module: Select a module Overall Score:	
Module 4 only: _____ Communication score: _____ Social Interaction	
Comm + Social Int: _____ DDC-GAS Score:	
Diagnosis/ADOS-2 Classification:	
☐Autism Disorder ☐Autism Spectrum Disorder ☐PDD-NOS ☐Other(s) Specify:	☐Yes ☐No
☐Not Qualified	
<u>Impairment in Social Communication and Social Interactions (*must have all 3*)</u>:	
☐Social-emotional reciprocity	
☐Nonverbal communicative behaviors used for social interaction	
☐Developing, maintaining, and understanding relationships	☐Yes ☐No
<u>Restricted, Repetitive or Stereotypical Patterns of Behaviors, Interests or Activities (*at least 2*)</u>:	
☐Stereotyped or repetitive motor movements, use of objects, or speech	
☐Insistence on sameness, inflexible adherence to routines, or ritualized patterns or verbal nonverbal behavior	
☐Highly restricted, fixated interests that are abnormal in intensity or focus	
☐Hyper- or hypo reactivity to sensory input or unusual interests in sensory aspects of the environment	☐Yes ☐No
☐Medical necessity and recommendation for ABA services determined by qualified licensed practitioner	☐Yes ☐No
Coordination with school/early intervention program: ☐Yes ☐No ☐Not school-aged	☐Yes ☐No
Coordination with individual's Primary Care Physician: ☐Yes ☐No	☐Yes ☐No
Notes:	
Case Action Requested:	
☐Not Qualified - Date AAN Sent	
☐Declined Benefit/Evaluation Only	
☐Enrollment to ASD Waiver per medical necessity and recommendation from qualified licensed practitioner	☐Yes ☐No

Initial/Update IPOS & Behavior Plan

Completed by CMH	PIHP
Update Hours per week ONLY (during current plan period): _____ to	
☐ Initial IPOS ☐ Update IPOS ADOS-2 Date: _____ Completed within 365 days: ☐ Yes ☐ No ADOS-2 Evaluator Name/Credential:	Criteria Met? ☐Yes ☐No
Behavioral Assessment Date: _____ Date completed: ☐ VB-MAPP ☐ ABLLS-R ☐ AFLS ☐ Other	☐Yes ☐No
Behavioral Plan of Care must contain: ☐ Specific targeted behaviors, with measurable, achievable, and realistic goals of achievement to increase functioning skills and independence ☐ Identification services can/will be delivered at home or in community ☐ Recommendation for service utilization (FBI/CBI) ☐ Incorporation of behavioral observation and direction ☐ Discharge Planning	☐Yes ☐No
IPOS must contain: ☐ Statement indicating ABA services do not include special education and related services ☐ Identification that services can/will be delivered at home or in community ☐ ABA Goal/Objective ☐ Amount, scope, and duration of ABA services per Behavioral Plan of Care and family input ☐ ABA services will include behavioral observation/supervision and direction by qualified provider ☐ Addresses risk factors of staff illness, vacation, etc. with specific contingency plan	☐Yes ☐No
IPOS Effective Date: _____ IPOS Expiration Date: Hours/week: _____ ABA Service Start Date: Offered right to choose service and provider: ☐Yes ☐No Agency Providing ABA Services: _____ Supervisor of ABA Services: Notes:	☐Yes ☐No

Discharge

Completed by CMH	PIHP
Exit ADOS-2 Completed Date: _____ ☐ No Exit ADOS-2 performed Module:select a module Overall Score:	Criteria Met? ☐Yes ☐No
Reason for Disenrollment: ☐ Met all treatment plan goals ☐ Moved out of state ☐ Voluntarily Disenrolled from Services ☐ Deceased ☐ Other ☐ Re-Evaluation did not meet medical necessity ☐ Age Off ☐ Approved-declined services ☐ No Longer Eligible for Medicaid	☐Yes ☐No
Date family notified: _____ Family requested hearing: ☐ No ☐ Yes	☐Yes ☐No
Disenrollment Date: _____	☐Yes ☐No
Reasons/Comments (if any):	☐Yes ☐No

Disposition/Utilization Management – Region 10 PIHP Office Use Only

☐ Full compliance

☐ Follow-up required:

Region 10 PIHP Autism Coordinator/Designee:_____ Date:

(Accepted as electronic signature)