Thurston-Mason BH-ASO Non-Medicaid Request Form

Provider Agency: _____

Requestor's Name: _____ Approving Supervisor's Name:_____

Client name:	**Client DOB:**

SECTION 1: FINANCIAL	
Reason for Request:	☐ Individual is uninsured; ☐ Individual's Medicaid benefit is in spend-down status; ☐ Individual has insurance but is unable to pay the co-pay or the deductible for services; ☐ Youth is requesting treatment without guardian consent; and/or, ☐ Individual's payor does not cover appropriate treatment services within the region.
	☐ Individual is using excessive Crisis Services due to inability to access non-crisis behavioral health services; and/or, ☐ Individual has more than five (5) visits over six (6) months to the emergency department, detox facility, or sobering center due to a SUD.
Income:	Monthly Income (Network Provider to verify): Number of members in the Household: *Individuals who do not qualify for Medicaid and have income up to two hundred twenty percent (220%) of the federal poverty level meet the financial eligibility for GFS/FBG services.*

SECTION 2: CLINICAL			
Date of request for service:		Available treatment start date:	
If providing SUD Interim Services, check all that apply:	☐ Referral for prenatal care and counseling on the effects of alcohol and drug use on the fetus; ☐ Brief screening; ☐ Development of a service plan; ☐ Individual and/or group contacts to assist the individual directly or by way of referral in meeting his/her basic needs; ☐ Updates to advise him/her of treatment availability, and information to prepare him/her for treatment; ☐ Counseling; ☐ Education; and, ☐ Referral regarding Human Immunodeficiency Virus (HIV) and tuberculosis (TB) education, if necessary a referral to treatment for HIV and TB.		
Start date of SUD Interim Services:			
Covered Behavioral Health diagnosis(es) (including F code) **and** LOCUS, CALOCUS, CANS, or ASAM Level of Care:			
SABG Funds are prioritized based on these specific populations. Please check all that apply for the individual:	☐ Woman who is pregnant and injecting drugs; ☐ Woman who is pregnant with a substance use disorder; ☐ Woman with dependent children; ☐ Individual who is injecting drugs All other populations prioritized as follows: ☐ Postpartum (up to one year, regardless of pregnancy outcome); ☐ Individual transitioning from residential care to outpatient care; ☐ Youth; ☐ Individual who is an offender (as defined in RCW 70.96A.350)		

High Risk Individual. Please check all that apply for the individual:	☐ Utilized crisis/emergency system(s) multiple times within a one (1) month period; ☐ Are at risk of imminent inpatient admission; ☐ Are recently (within the last 30 days) discharged from a 24-hour facility. This includes: E&Ts, WSH, City or County Jails, Department of Corrections; ☐ Are recently discharged from a 24-hour facility and are on a LRA or CR; ☐ Have a history of multiple crisis or inpatient services;
Anticipated length of treatment supported by non-Medicaid funds:	☐ Residential treatment (SABG funds coincide with approval of utilization reviews) ☐ Intensive outpatient treatment (not to exceed 3 months without review) ☐ Outpatient treatment (not to exceed 6 months without review)
Justification for consideration of non-Medicaid funds for services. Include information regarding planned services and discharge. _____ _____ _____ _____ _____	

SECTION 3: FOR TM BH-ASO USE ONLY		
Date Received:	Date Sent to Provider:	Length of Treatment Approved:
☐ Approved ☐ Denied	Reason:	Care Manager Signature:
Fiscal Review: ☐ Approved ☐ Denied		Fiscal Signature:

INSTRUCTIONS:

- Call Thurston-Mason BH-ASO to verify available funding
- Complete top portion of form, including client identifying information.
- Section 1: Financial
  a. Select individual's financial reason for funds and verify monthly income.
- Section 2: Clinical
  a. Enter the most recent behavioral health diagnosis documented in the individual's chart.
  b. Select each priority population that applies to the individual.
  c. Select the number of months anticipated for funds.
  d. Enter brief summary of current clinical needs and justification for requesting funding exception.
- Complete the excel document titled, Thurston-Mason BH-ASO Non-Medicaid Services
- Secure email to oprequest@tmbho.org using the file name with the date of the request:

  Non-Medicaid_Request_Form_MM.DD.YY

  Thurston-Mason BH-ASO Non-Medicaid Services_MM.DD.YY

You will receive a decision or request for additional information within five (5) days of receipt of written request.