

Thurston-Mason BH-ASO Non-Medicaid Request for Non-Medically Necessary Services 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;
 - ☐ Individual has a Medicaid benefit;
 - ☐ Youth is requesting treatment without guardian consent; and/or,
 - ☐ Individual's payor does not cover appropriate treatment services within the region.
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- ☐ 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

Date of request for service:

Available service start date:

Anticipated length of service (also complete the Thurston-Mason BH-ASO Non-Medicaid Services form indicating specific services):

Is the individual a resident of Mason or Thurston County?

- ☐ Yes
- ☐ No

REQUIRED for Non-Medically Necessary services:

What type of behavioral health services is the individual currently enrolled?

- ☐ MH
- ☐ SUD

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;

SECTION 3: FOR THURSTON-MASON BH-ASO USE ONLY		
Date Received:	Date Sent to Provider:	Length of Treatment Approved:
<input type="checkbox"/> Approved <input type="checkbox"/> Denied	Reason:	Care Manager Signature:
Fiscal Review: <input type="checkbox"/> Approved <input type="checkbox"/> 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 or active Medicaid benefit.
- Section 2
 - a. Indicate request date, start date, and anticipated length (also complete the Thurston-Mason BH-ASO Non-Medicaid Services form)
 - b. Select each priority population that applies to the individual.
- Complete the excel document titled, Thurston-Mason BH-ASO Non-Medicaid Services
- Upload forms to your agency's SFTP site for review 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.