Virginia Department of Behavioral Health and Developmental Services

# DIVISION OF DEVELOPMENTAL SERVICES
# VIRGINIA SIS® REASSESSMENT REQUEST FORM

1. **Date request submitted:** *Click to enter date*

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?*

4. **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* | |

6. **Describe any additional pertinent information:**
   *Briefly describe any additional relevant information.*

INDIVIDUAL'S NAME
DATE SUBMITTED

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**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: SIS@dbhds.virginia.gov

INDIVIDUAL'S NAME
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**—SECTION BELOW FOR DDS USE ONLY—**

**Date DBHDS SIS Team 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 Waiver Reassessment Quality Manager for DDS review

DBHDS Signature*: Click or tap to sign* Date: *Click to enter date*

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**DDS Review:**

☐ Approved ☐ Denied

**Notes:** *Click here to enter notes.*

**DDS Signatures:**

Waiver Assessment Quality Specialist

*Click or tap to sign* Date*: Click to enter date*

Waiver Assessment Quality Manager

*Click or tap to sign* Date: *Click to enter date*